Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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Original Public Report

Report Issue Date: August 2, 2023
Inspection Number: 2023-1193-0005
Inspection Type: Proactive Compliance Inspection
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partner
Long Term Care Home and City: Orchard Villa, Pickering

Lead Inspector	**Inspector Digital Signature**
Julie Dunn (706026)	Julie Dunn Digitally signed by Julie Dunn Date: 2023.08.03 13:40:52 -04'00'

Additional Inspector(s)
Sami Jarour (570)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17-21, and 24-25, 2023

The following intake(s) were inspected:

- Intake: #00092020 - Orchard Villa PCI

The following **Inspection Protocols** were used during this inspection:

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Admission, Absences and Discharge
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
During the initial tour of the home, it was observed that the home's policy on the Prevention of Abuse and Neglect was not posted on the information board on the main level.

The Director of Care acknowledged that the home's policy Zero Tolerance of Resident Abuse and Neglect was not posted on the information board.

Two days later, a copy of the home's policy Zero Tolerance of Resident Abuse and Neglect policy was posted on the information board on the main floor.

Sources: Observations; and interview with Director of Care. [570]

Date Remedy Implemented: July 19, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 19

The licensee has failed to ensure that windows in the home that opened to the outdoors and accessible to residents had a screen and could not be opened more than 15 centimeters.

Rationale and Summary
During the initial tour of the home, it was observed that the window accessible to residents in a resident room could not be opened. The window was restricted from opening by two screws blocking the track.

An observation of the resident room was conducted with the Executive Director. The Executive Director acknowledged that the window had no screen and was restricted from opening. The Executive Director indicated the window would be repaired by maintenance staff.

On a subsequent date, Inspector #570 observed the same resident room; the window was noted to have a screen installed and could be opened less than 15 centimeters.

Not ensuring the windows accessible to residents had screens and properly maintained puts residents' safety at risk.

Sources: Observations; interview with Executive Director. [570]

Date Remedy Implemented: July 24, 2023

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (d)

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect contained an explanation of the duty under section 28 to make mandatory reports specific to unlawful conduct that resulted in harm or a risk of harm to a resident.

Rationale and Summary
FLTCA, 2021, s. 28 (1) states a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System

Integration Act, 2006 or the Connecting Care Act, 2019.

A review of the licensee's policy of Zero Tolerance of Resident Abuse and Neglect (policy # RC-02-01-02, last reviewed January 2023) indicated the policy on page four related to reporting, the immediate reporting requirements of unlawful conduct that resulted in harm or a risk of harm to a resident.

The Director of Care acknowledged that the Zero Tolerance of Resident Abuse and Neglect policy did not include the immediate reporting requirement of unlawful conduct that resulted in harm or a risk of harm to a resident.

Not including all situations where the licensee is required to immediately report to the Director could result in incidents that resulted in harm or risk of harm to residents not immediately reported to the Director.

Sources: The licensee's policy of Zero Tolerance of Resident Abuse and Neglect (policy # RC-02-01-02, last reviewed January 2023) and interview with the Director of Care. [570]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to restrict unsupervised access by a resident to a utility room containing multiple electrical panels.

Rationale and Summary
During an interview, a resident communicated that they accessed the utility room in a home area, in order to flip an electrical breaker when needed. The resident indicated that the access code for the utility room was the same access code as the code used for the elevators and stairway doors in the long-term care (LTC) home. The resident described that they used the access code to open the door to the utility room and then opened an electrical panel door to flip a breaker when needed.

A list of access codes provided to the inspectors by the LTC home included a four-digit numeric code that was required for the main elevator, and the list indicated that the same four-digit numeric code was used for all other codes.

During an observation, inspector entered the four-digit code in the keypad of the utility room, and the utility room door unlocked. Inspector entered the utility room and observed electrical panels on the walls and a utility sink at the back of the room.

During an interview, the Executive Director indicated a resident should not have access to a utility room and electrical panels, acknowledged that it was a safety concern and indicated it would be resolved. The Executive Director indicated they had been unaware that a resident could access the utility room and electrical panels.

By failing to restrict unsupervised access to a utility room containing multiple electrical panels, the licensee put the resident at risk for injury.

Sources: Observations, List of Access Codes, and interviews with a resident and the Executive Director. [706026]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary
During an observation in a resident room, two call bell cords were observed hanging down from the overbed light fixture with the push buttons to activate the call bell below the light fixture. A resident's substitute decision-maker (SDM) was in the room and attempted to use the call bell for staff to assist the resident. The call bell was hard to reach as the cords with push buttons were hanging from the overbed light fixture.

A Personal Support Worker indicated that the call bell should be accessible to the resident and should be kept on the bed or chair by the resident. The PSW moved the call bell cords from the light fixture and placed one cord on the bed at the head of the bed and the other cord on the comfy chair next to the bed.

The Executive Director indicated the expectation is that the call bell is within reach of the residents.

Not ensuring the call bell was accessible to residents, staff and visitors at all times puts residents at risk of harm should they need to use the call bell in an emergency.

Sources: Observation of a resident's room and interviews with a PSW and the Executive Director. [570]

WRITTEN NOTIFICATION: COOLING REQUIREMENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (4) (b)

The licensee failed to ensure environmental measures from the heat related illness prevention and management plan for the home were implemented when the temperature in areas of the home measured by the licensee reached 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary
Air temperature logs provided by the long-term care home showed handwritten temperatures documented each morning, afternoon and evening. Review of the home's air temperature logs from a specific date, indicated air temperatures in four of the six home areas, including hallways, resident lounges and resident rooms, were documented as 26 degrees Celsius or above.

Handwritten notes on the air temperature log for the specific date indicated that actions taken in one specific home area were, "checked all AC operational" and "closed WN" (windows). There were no action items documented for the other three home areas. Review of the air temperature logs for the following day, indicated that air temperatures in the other three home areas were at 26 degrees Celsius or above. The logs showed that air temperatures in the home area where documented actions had been implemented were below 26 degrees Celsius on the following day.

In an interview, the Executive Director indicated that two home areas had central air conditioning, and in the other home areas there were portable air conditioning units in each resident room, in lounges, dining rooms and at nursing stations.

In an interview, the Environmental Services Supervisor (ESS) reviewed the air temperature logs for the specific date and the following day, and indicated that it would have been noted on the logs if any corrective actions were taken in the home areas where the air temperature was recorded as 26 degrees Celsius or above. The ESS indicated that actions to lower the air temperatures to acceptable range could include to turn up the air conditioning, or to open the windows if there is a cool breeze coming in.

The LTC home's Preventing Heat Related Illnesses Policy stated that environmental measures to prevent heat-related illness include: closing windows, drapes and blinds during the day; identifying one or more areas where residents may go to seek refuge from the heat; and, when possible, turning off lights to reduce the temperature in the room.

Failure to ensure environmental measures from the heat related illness prevention and management plan were implemented when the air temperature was 26 degrees Celsius or above in resident areas of the LTC home increased the residents' risk for heat related illness.

Sources: The home's Preventing Heat-Related Illnesses Policy, Air Temperature Records, interviews with ESS and Executive Director. [706026]