

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 8, 2025

Inspection Number: 2025-1193-0003

Inspection Type:

Critical Incident

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Orchard Villa, Pickering

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2, 3, 4, 7, 8, 2025

The following intake(s) were inspected:

- Intake: #00140711 - Critical Incident Report (CIR) related to an allegation of abuse of a resident.

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of the care set out in the plan of care for a resident was documented on a specified day.

Sources: Resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from abuse by a staff member during the provision of care, causing an injury to the resident.

.Documentation and an interview with the Director of Care (DOC) indicated the allegation was founded.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Sources: Critical Incident Report, resident’s clinical records, investigation notes and staff interviews.

WRITTEN NOTIFICATION: Notification re personal belongings,

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 42 (a)

Notification re personal belongings, etc.

s. 42. Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,

(a) the resident's personal aids or equipment are not in good working order or require repair; or

The licensee failed to ensure that the substitute decision-maker of a resident was notified when the resident's equipment was not in a good state of repair.

The occupational therapist (OT) confirmed that the resident's equipment was not in good repair and needed to be replaced. Documentation did not indicate that the resident's SDM was notified of the condition of the equipment.

Sources: Inspector's observation and interview with OT.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber when a registered staff member did not administer an as-needed medication to a resident

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

as ordered by a physician.

Sources: Critical Incident Report, resident's clinical records, investigation notes and staff interviews.

COMPLIANCE ORDER CO #001 Plan of care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

- 1- The DOC and or designate shall review the plan of care for a specified resident with all staff from all shifts involved in the provision of care to the resident. The review shall focus on the provision of care and the level of support needed to ensure the resident's safety during the provision of care.
- 2- The DOC and or designate shall conduct weekly audits for four weeks to ensure the provision of care to the specified resident is completed as directed in the plan of care.
- 3- The DOC and or designate shall keep a record of the plan of care review and the audits completed, including any corrective actions taken. These records should be available to Inspectors upon request.

Grounds

The licensee has failed to ensure that the care set out in a specified resident's plan of care was provided to the resident as specified in the plan related to the provision of care.

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

The resident's plan of care stated that the resident required assistance for the provision of care.

On a specified day and shift, a resident complained of pain and was to sustain an injury after a staff member did not use the required assistance during the provision of care to the resident. Point of care documentation (POC) during a specified month indicated that the resident did not receive the required assistance during the provision of care on multiple shifts. The Director of Care (DOC) indicated that a specified staff member did not use the required assistance when they attempted to provide care to the resident, causing an injury to the resident.

Failure to ensure that staff followed the plan of care of a resident increased the risk of harm and led to actual injuries for the resident.

Sources: Critical Incident Report, resident's clinical records, investigation notes and staff interviews.

This order must be complied with by July 11, 2025

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

REVIEW/APEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.