Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 24, 2016	2016_327570_0010	003109-16	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 25- 29, May 02 & 03, 2016

Complaint intake number #003109-16 was inspected related to staff to resident alleged abuse. The following critical incidents intakes related to staff to resident alleged abuse were reviewed and inspected upon concurrently with this inspection: intake # 003109-16, 033355-15, 033880-15, 004180-16 and 011214-16.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Director of Quality (DOQ), Registered Nurses (RN), Resident Care Area Managers (RCAM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Occupational Therapist (OT).

Also completed in the inspection: observation of staff to residents interactions;, observation of dining services, review of clinical health records of identified residents, relevant policies, licensee's internal investigations, staff educational records, and complaint logs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6. (4) (b), by not ensuring that the staff and others involved in the different aspects of care for resident #002 collaborate with each other in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other.

Related to Log #033880-15 for resident #002:

Review of clinical records for resident #002 indicated the resident is totally dependent on staff for toileting needs. According to Personal Support Workers and Registered Nursing Staff resident is incontinent but able to call for assistance if they want to have a bowel movement.

The home submitted Critical Incident Report (CIR) on a specified date for an incident involving resident #002. As per CIR, resident #002 rang the call bell and requested assistance from PSW #105 that they needed a bedpan for bowel movement. PSW #105 turned off the call bell and told the resident that it was meal time and they had to wait, and the assigned PSW #106 will be informed; PSW #105 walked away. When PSW #106 brought resident #002's meal tray, she/he found the resident emotionally upset and had been incontinent of bowel in bed; PSW #106 provided personal care and changed bed linens.

The plan of care for resident #002 in effect at time of incident directs the following:
- Toileting - Call bell to be within reach, and remind resident to use call bell to call staff; Total Dependence. Full staff performance of activity during entire shift.
- Bowel Continence - Incontinent - Had inadequate control of bowel - Use bedpan when in bed when requesting or having the urge.

Interview with RPN #113 and PSW #112 indicated to the inspector that whenever resident #002 requested a bedpan, it was provided right away and that PSW staff can ask registered staff to assist if a second PSW was not available.

Interview with the DOC and review of the licensee's internal investigation notes indicated that PSW #105 did not provide assistance to resident #002 as directed in the plan of care and did not report to other PSWs or registered staff that resident #002 had requested to be toileted, stating that she/he was busy with other residents and forgot to report to charge nurse. [s. 6. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff collaborate with each other in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 23. (2), by not ensuring that the results of the abuse or neglect investigation were reported to the Director.

Related to Log #033880-15 for resident #002:

Under O. Reg. 79/10, s. 104 (3), when making a report to the Director under subsection 23 (2) of the Act, if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director (in 21 days unless otherwise specified by the Director).

The home submitted Critical Incident Report (CIR) under s. 24 Abuse/Neglect on a specified date for an incident involving resident #002.

Interview with the DOC indicated that resident #002 reported the incident to staff on a specified date for an incident that occurred on a specified previous shift . The incident was called in to the MOHLTC on same day when the incident was reported by the resident.

Review of the home's investigation notes indicated that the investigation was concluded on a specified date within three days after the incident was reported.

Review of Critical Incidents System and interview with the DOC confirmed that the Director was not notified of the results of the investigation. The CIR was later amended on a specified date, over four months following the incident, to include the results of the investigation. [s. 23. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the results of the abuse or neglect investigation were reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 104 (2), by not ensuring that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to Log #011214-16 for resident #005

An incident involving resident #005 was called in to the MOHLTC on a specified date and time. The incident summary indicated that resident #005 reported to their spouse that they were physically abused; the resident could not describe the incident; the police was notified.

Interview with the DOC indicated the incident was reported to her. The DOC investigated the incident and spoke to the resident's spouse two days following the incident. The DOC confirmed the CIR was not submitted as required within 10 days as it was missed. The CIR was later submitted to the Director on a specified date over one month following the incident. [s. 104. (2)]

Issued on this 27th day of May, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.