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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 21, 2019	2019_598570_0005	006538-18, 009314-18, 009543-18, 015513-18, 019959-18, 020274-18, 020491-18, 020992-18, 025112-18, 025677-18, 026997-18, 028500-18, 032391-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes 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), PATRICIA MATA (571), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): Februrary 19, 20, 21, 22, 25, 26, 27, 28 and March 1, 4, 5, 6, 7, 8, 11, 2019.

During the course of the inspection, the following logs were inspected concurrently:
Log #006538-18, Critical Incident Report related to an allegation of abuse.
Log #009314-18, Critical Incident Report related to a fall resulting in an injury.
Log #009543-18, Critical Incident Report related to a fall resulting in an injury.
Log #015513-18, Critical Incident Report related to a fall resulting in an injury.
Log #019959-18, Critical Incident Report related to an allegation of abuse.
Log #020274-18, Critical Incident Report related to an allegation of abuse.
Log #020491-18, Critical Incident Report related to an allegation of abuse.
Log #020992-18, Critical Incident Report related to an allegation of abuse.
Log #025112-18, Critical Incident Report related to a fall resulting in an injury.
Log #025677-18, Critical Incident Report related to a fall resulting in an injury.
Log #026997-18, Critical Incident Report related to a fall resulting in an injury.
Log #028500-18, Critical Incident Report related to an allegation of abuse.
Log #032391-18, Critical Incident Report related to a fall resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Residents Care Area Managers (RCAM), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), the RAI Coordinator, Behavioural Support staff (BSO), the Scheduling Clerk, residents and families.

In addition, the inspectors reviewed clinical medical records, the licensee's internal investigations and related policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 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	Légende 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Related to log #009543-18:

Critical Incident Report was submitted to the Director on an identified date and time. The CIR indicated that on an identified date and time, resident #005 was found on the floor in their room. The resident was sent to hospital for further assessment and was diagnosed with an injury to a body part.

A review of resident #005's current plan of care indicated that the resident was at an identified risk for falls. The plan of care directed that a specified intervention to be applied for falls prevention.

On an identified date and time, Inspector #570 observed resident #005 sitting in their mobility device. Inspector noted the specified intervention was not in place.

During an interview on identified date, Personal Support Worker (PSW) #118 indicated to Inspector #570, that they assisted resident #005 to sit in the mobility device and that the specified intervention was not applied. The PSW indicated no awareness if the resident's plan of care includes the use of specified intervention.

During an interview on identified date, Registered Practical Nurse (RPN) #125 indicated to Inspector #570, that resident #005 was at an identified risk for falls and required the use of a specified intervention. The RPN indicated no awareness that resident did not have the specified intervention in place on specified date. The RPN further indicated that on specified date, a causal PSW staff was assigned to the resident and that the PSW staff should have checked the resident's plan of care and approach registered staff for

directions.

During separate interviews, PSWs #126 and #129 indicated to Inspector #570, that they apply the specified intervention to resident #005 when the resident is transferred out of bed. [s. 6. (7)]

2. A review of resident #005's progress notes for specified date, RPN #125 documented that at specified time the resident was found sitting on the floor in bathroom. The resident had been given routine toileting and was left unattended while the staff attended to another resident. RPN #125 documented that staff was to always remain with resident as the resident should not be left alone during toileting.

A review of resident #005's plan of care, indicated that resident #005 self-transfers and had falls related to toileting. The plan of care directed not to leave resident alone in the bathroom.

During separate interviews, PSW #130 and #131 indicated to Inspector #570, that on an identified date and time, they transferred resident #005 to the toilet. PSW #130 and #131 further indicated that they left resident #005 on the toilet unattended to attend to another resident.

During an interview, RPN #125 indicated to Inspector #570, that resident #005 was found sitting on the floor in front of the toilet. The RPN indicated that staff should have stayed with the resident when being toileted as directed in the plan of care. The RPN confirmed that the resident's plan of care was not followed.

During an interview, the Director of Care (DOC) indicated to Inspector #570, that the incident on an identified date was investigated and determined that staff did not follow the plan of care for the resident. The DOC indicated that it is an expectation that staff should follow resident's plan of care at all times.

The licensee did not ensure that care was provided to resident #005 as directed in the plan of care. [s. 6. (7)]

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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. (3) 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. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the preliminary report made to the Director within 10 days, was followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to Log # 019959-18:

Critical Incident Report (CIR) was submitted to the Director on an identified date, for an allegation of resident to resident abuse. The CIR indicated the incident occurred on an identified date time when resident #016 reported that resident #015 caused an injury to a body part.

During an interview, the Director of Care (DOC) confirmed to Inspector #570 that a final report was not provided to the Director in a timely manner due to a change in management at the home.

The final report to the Director was not submitted indicating the outcome of the licensee's investigation until an identified date (greater than 21 days). [s. 104. (3)]

Issued on this 25th day of March, 2019

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

Original report signed by the inspector.