Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Central East Service Area Office
419 King Street West Suite #303
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419, rue King Ouest bureau 303
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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
Jul 24, 25, 2019	2019_670571_0011	010700-19	Critical Incident System

Licensee/Titulaire de permis

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

PATRICIA MATA (571)

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): July 3, 4 and 5, 2019

Log #010700-19 related to an incident that causes an injury for which the resident is taken to the hospital.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Physician, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **1 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. (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).

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 failed to ensure that RPN #101 collaborated with physician #104 when the RPN suspected that resident #001 sustained an injury.

Log #010700-19:

A CIR was submitted for an incident that occurred that resulted in a fall and injury of resident #001. On a specified date and time, resident #001 sustained an injury while care was being provided by PSW #100.

A review of the progress notes for resident #001 indicated that on a specified date and time, resident #001 fell and sustained an injury and was experiencing pain to two specified areas. Medication was administered for pain. Two hours after the resident fell, RN Supervisor #102 documented they that were called to assess the resident. The resident displayed an identified symptom from the injury and complained of severe pain to an identified area of their body. RN Supervisor #102 instructed RPN #101 to inform the Substitute Decision Maker (SDM) and see if the SDM wanted resident #001 sent to the hospital for further treatment and evaluation. Approximately three- and one-half hours after the incident, RPN #101 documented that resident one was exhibiting an identified symptom and severe pain was also noted. The resident displayed physical evidence of pain and was verbalizing that they were in pain. The SDM was informed of the fall and assessment of the resident. The SDM instructed that they wanted the physician to assess the resident in the home in the morning. Approximately five hours after the incident occurred, on the next shift, RN Supervisor #103 documented that the resident

was experiencing pain during personal care. The resident exhibited clear signs of injury to an identified area of their body. The SDM was called and the resident was transferred to the hospital.

On a specified date, the resident was admitted to the hospital with an identified diagnosis.

In an interview with Inspector #571, the DOC indicated that the resident was not transferred to the hospital immediately. Resident #001 was transferred to the hospital on the next shift when the RN came in and assessed the resident for complaint of pain and observed symptoms of injury. The physician was not informed of the fall and pain until the following day after the resident was transferred to hospital.

In an interview with Inspector #571, RPN #101 indicated that they suspected the resident had sustained an identified injury and were trying to manage the resident's discomfort. They did not call the physician; they were going to observe the resident and have the physician see the resident the following morning. RPN #101 gave the resident medication for pain after the incident. They indicated that the resident had felt more comfortable after the administration of the medication.

In an interview with Inspector #571, RN #102 indicated that the RPN would normally complete the assessment after the identified incident. The RN came to the unit where resident #001 resided. The RN asked RPN #101 about the resident's condition and instructed RPN #101 to call the SDM to inform them of the incident. RN #102 indicated that RPN #101 should have informed the physician.

In an interview with Inspector #571, physician #104 indicated that if a staff member suspected an identified injury, they should send the resident to the hospital or call the physician to discuss. If the SDM doesn't wish the resident to go to the hospital, then the SDM's wishes take precedence over the physician. The physician was made aware of the incident the morning following the incident.

The licensee failed to ensure that RPN #101 collaborated with the physician, after the SDM decided that the resident should wait to be seen by physician in the morning. The RPN suspected that resident #001 sustained an identified injury after the fall when the resident exhibited an identified symptom and complained of severe pain but the physician was not notified until the following morning after the resident was transferred to hospital. [s. 6. (4) (a)]

2. The licensee has failed to ensure that resident #001 was provided care as specified in the plan of care.

Log #010700-19:

A CIR was submitted for an incident. On an identified date and time, resident #001 fell and sustained an injury while care was being provided by PSW #100.

A review of the care plan in place on the day of the incident for resident #001 indicated that the resident required two staff to provide an identified care need.

A review of the progress notes related to the incident on the specified date indicated that resident #001 sustained an injury during the provision of care. The resident required hospitalization for an identified diagnosis related to injury from the incident.

In an interview with Inspector #571, the DOC indicated that as per resident #001's care plan, two staff were to provide care to the resident. PSW #100 was aware two staff were to be present during care.

In an interview, PSW #100 indicated that on the identified date, they were providing care to resident #001. An identified incident occurred during the provision of care. PSW #100 acknowledge that they knew the resident required two staff for the identified area of care. PSW #100 had provided the identified area of care alone to the resident in the past. PSW #100 explained that the care plans for the residents were available and accessible.

The licensee failed to ensure that PSW #100 provided care to resident #001 as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 by ensuring that Registered Staff collaborate with the physician when a fracture is suspected after a fall, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, that the policy was complied with.

Log #010700-19:

A CIR was submitted for an incident. On an identified date, resident #001 sustained an injury while care was being provided by PSW #100.

In accordance with O. Reg 79/10, s.48 (1) every licensee of a long-term care home shall ensure that 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management

Program" policy #RC-15-01-01 last revised February 2017. Appendix nine "Post Fall Clinical Pathway" of the policy indicates that after a resident has a fall, a focused assessment by the first Registered staff person on the scene is completed and a clinical decision by the Registered staff is made whether the resident will be moved.

A review of the progress notes for resident #001 indicated that on a specified date, the resident experienced a fall.

A review of the licensee's investigation notes indicated that in their interview with PSW #100, the PSW informed the Director of Care that they transferred resident #001 from the floor to the bed after the fall and provided care to the resident before a Registered staff member had assessed the resident for injury.

In an interview Inspector #571, the DOC indicated that PSW #100 transferred resident #001 back to bed after a fall and proceeded to provide care after calling PSW #105 to help. One PSW transferred the resident back to bed and two PSWs provided care before a registered staff assessed the resident.

In an interview with Inspector #571, PSW #100 indicated that on a specified date, they were providing care to resident #001 and during the care, the resident fell out of bed. PSW #100 proceeded to return the resident to bed using a mechanical lift and continued to provide care to the resident before a registered staff member had assessed the resident for injury. PSW #100 indicated that they knew they were not to move the resident until a registered staff assessed the resident.

The licensee failed to ensure PSW #100 complied with their Fall Prevention and Management Program policy. [s. 8. (1) (a),s. 8. (1) (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 by ensuring a Registered staff member assesses all residents after a fall before they are moved, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #100 used safe transferring techniques when assisting resident #001.

Log #010700-19:

A CIR was submitted for an incident on identified date.

A review of the licensee's policy LP-01-01-02 titled "Mechanical Lifts" Last Updated August 2017 included the following: "Two trained staff are required at all times when performing a Mechanical Lift. All breaches of the Mechanical Lift policy or procedure will result in an investigation and may result in progressive discipline up to and including terminations."

A review of the licensee's investigation notes indicated that in an interview with PSW #100, the PSW informed the Director of Care that they transferred resident #001 using a mechanical lift. PSW #100 did not have the assistance of a second staff member.

In an interview with Inspector #571, the DOC indicated that PSW #100 transferred resident #001 without assistance using a mechanical lift and was aware that two staff were required.

In an interview with Inspector #571, PSW #100 indicated that on a specified date, when they were providing care to resident #001 they transferred the resident using the mechanical lift without the presence of a second staff member. PSW #100 acknowledged that they knew the resident required two staff for transfers.

The licensee failed to ensure that PSW #100 used safe transferring techniques. [s. 36.]

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 by ensuring staff use safe transferring techniques, to be implemented voluntarily.

Issued on this 31st day of July, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	PATRICIA MATA (571)
Inspection No. / No de l’inspection :	2019_670571_0011
Log No. / No de registre :	010700-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 24, 25, 2019
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Lesreen Thomas

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically, the licensee must:

1) Ensure Personal Support Workers (PSW), are made aware that they must follow the plan of care for residents, related to the number of staff members required for personal care, by providing education and a documented record must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was provided care as specified in the plan of care.

Log #010700-19:

A CIR was submitted for an incident. On an identified date and time, resident #001 fell and sustained an injury while care was being provided by PSW #100.

A review of the care plan in place on the day of the incident for resident #001 indicated that the resident required two staff to provide an identified care need.

A review of the progress notes related to the incident on the specified date indicated that resident #001 sustained an injury during the provision of care. The resident required hospitalization for an identified diagnosis related to injury from the incident.

In an interview with Inspector #571, the DOC indicated that as per resident

#001's care plan, two staff were to provide care to the resident. PSW #100 was aware two staff were to be present during care.

In an interview, PSW #100 indicated that on the identified date, they were providing care to resident #001. An identified incident occurred during the provision of care. PSW #100 acknowledge that they knew the resident required two staff for the identified area of care. PSW #100 had provided the identified area of care alone to the resident in the past. PSW #100 explained that the care plans for the residents were available and accessible.

The licensee failed to ensure that PSW #100 provided care to resident #001 as specified in the plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA and three or fewer compliance orders that included:
- compliance order (CO) issued on September 8, 2016 (2016_327570_0014) with a compliance date of October 31, 2016
- written notification (WN) issued on November 25, 2016 (2016_327570_0022)
- written notification (WN) issued on March 9, 2017 (2017_360111_0001)
- Director's referral (DR) with CO issued on November 8, 2017 (2017_643111_0013) with a compliance due date of November 15, 2017
- voluntary plan of correction (VPC) issued on March 21, 2019 (2019_598570_0005)

(571)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Mata

Service Area Office /
Bureau régional de services : Central East Service Area Office