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
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_655679_0030	015078-19	Follow up

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

MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 4-8, 2019.

The following intake was inspected upon during this Follow Up Inspection.

- One intake related to Compliance Order (CO) #001 from Inspection 2019_670571_0011, regarding section 6. (7) of the Long-Term Care Home's Act, 2007, for care not being provided as specified in the plan of care.

A Critical Incident Report (#2019_655679_0028) and a Complaint Inspection (#2019_655679_0029) were conducted concurrently with this inspection.

PLEASE NOTE: A CO related to s. 6. (7) of the Long-Term Care Home's Act, 2007, identified in a concurrent inspection #2019_655679_0028 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Registered Nurse (RN) Supervisor, Restorative Care Registered Practical Nurse (RPN), RNs, RPNs, Resident Assessment Instrument (RAI) Coordinator Backup, Housekeeping Aides, Personal Support Workers (PSWs), residents and families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

Ad-hoc notes were used during this inspection.

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

- **1 WN(s)**
- **0 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. (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 for resident

#007 was provided as specified in the plan.

During inspection #2019_670571_0011, compliance order (CO) #001 was issued to address the licensee's failure to comply with s. 6. (7) of the Long Term Care Home's Act (LTCHA), 2007. The CO ordered the home to:

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.

The compliance due date for this order was October 31, 2019.

While the licensee complied with section one of the order, additional non-compliance with the requirements of s. 6 (7) of the Long Term Care Home's Act was identified.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #007 had a fall on a specified date. The fall resulted in a transfer to hospital where it was determined that the resident had a specified injury.

Inspector #757 reviewed resident #007's current care plan, which indicated that staff were to ensure that a specified intervention was in place at specified times.

During an observation on a specified date, resident #007 was noted to be in their room and their specified intervention was not in place. Upon further observations, the resident's specified intervention was observed to be located in another area of the resident's room.

During an interview with PSW #126, they confirmed that the resident's intervention was not in place as specified in the care plan.

During an interview with RPN #127, they indicated that resident #007 required a specified intervention The RPN noted that if the resident was in their room without the specified intervention in place, then care was not provided according to the plan of care.

During an interview with RN #125, they indicated that resident #007's specified

intervention should have been in place in order to provide care as specified in the plan of care.

During an interview with the Director Of Care (DOC), they confirmed that resident #007's specified intervention should have been in place as per the care plan. [s. 6. (7)]

2. A CI report was submitted to the Director related to a fall of resident #008 resulting in an injury.

Inspector #744 reviewed resident #008's current care plan, which indicated that staff were to implement two specified interventions.

Inspector #744 observed resident #008 on two occasions without the two specified interventions in place. This observation was confirmed by PSW #109.

In an interview with Inspector #744, PSW #109 stated that one of the specified interventions for resident #008 had been missing for a specified period of time and that the other intervention was unable to be implemented due to a specified reason.

In an interview with Inspector #744, the DOC stated that staff were to ensure that the interventions listed in the care plan were always in place. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 6th day of December, 2019

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) :	MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)
Inspection No. / No de l’inspection :	2019_655679_0030
Log No. / No de registre :	015078-19
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 6, 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

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jason Gay

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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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_670571_0011, CO #001;

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 Long Term Care Homes Act 2007.

Specifically, the licensee shall:
1) Develop an auditing tool and schedule to ensure that residents #007, #008, and all residents of the home who are at a high risk for falls receive care as specified in their care plan; and

2) Maintain records of the audits and the actions taken to rectify identified deficiencies. The records shall include the date, time, location, residents involved, staff involved, the name and classification of the person completing the audit, any corrective actions taken and the outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #007 was provided as specified in the plan.

During inspection #2019_670571_0011, compliance order (CO) #001 was issued to address the licensee's failure to comply with s. 6. (7) of the Long Term Care Home's Act (LTCHA), 2007. The CO ordered the home to:

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.

The compliance due date for this order was October 31, 2019.

While the licensee complied with section one of the order, additional non-compliance with the requirements of s. 6 (7) of the Long Term Care Home's Act was identified.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #007 had a fall on a specified date. The fall resulted in a transfer to hospital where it was determined that the resident had a specified injury.

Inspector #757 reviewed resident #007's current care plan, which indicated that staff were to ensure that a specified intervention was in place at specified times.

During an observation on a specified date, resident #007 was noted to be in their room and their specified intervention was not in place. Upon further observations, the resident's specified intervention was observed to be located in another area of the resident's room.

During an interview with PSW #126, they confirmed that the resident's intervention was not in place as specified in the care plan.

During an interview with RPN #127, they indicated that resident #007 required a specified intervention The RPN noted that if the resident was in their room without the specified intervention in place, then care was not provided according to the plan of care.

During an interview with RN #125, they indicated that resident #007's specified intervention should have been in place in order to provide care as specified in the plan of care.

During an interview with the Director Of Care (DOC), they confirmed that resident #007's specified intervention should have been in place as per the care

plan. (679)

2. A CI report was submitted to the Director related to a fall of resident #008 resulting in an injury.

Inspector #744 reviewed resident #008's current care plan, which indicated that staff were to implement two specified interventions.

Inspector #744 observed resident #008 on two occasions without the two specified interventions in place. This observation was confirmed by PSW #109.

In an interview with Inspector #744, PSW #109 stated that one of the specified interventions for resident #008 had been missing for a specified period of time and that the other intervention was unable to be implemented due to a specified reason.

In an interview with Inspector #744, the DOC stated that staff were to ensure that the interventions listed in the care plan were always in place.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents #007 and #008. The scope of the issue was a level 2 as it related to two of four residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of the LTCHA and four or more compliance orders that included:
- A Written Notification (WN) issued on March 9, 2017 (2017_360111_0001)
- A Director's referral (DR) with CO issued on November 8, 2017 (2017_643111_0013) with a compliance due date of November 15, 2017;
- A Voluntary Plan of Correction (VPC) issued on March 21, 2019 (2019_598570_0005); and,
- A Compliance order (CO) issued on July 25, 2019 (2019_670571_0011) with a compliance due date of October 31, 2019.
(679)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 21, 2020

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 6th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

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