Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux 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
May 26, 2020	2020_838760_0005	022070-19, 022624-19, 023183-19, 001230-20	Complaint

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

JACK SHI (760)

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): February 25, 26, 27, 28 and March 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 2020

The following intakes were completed in this complaint inspection:
Log related to missing baths.
Log related to availability of supplies.
Log related to various care concerns..

A follow up to Compliance Order (CO) #001, s. 6 (7), related to providing care set out in the resident's plan of care, issued under inspection #2019_655679_0030, on December 6, 2019, with a compliance date of Feb 21, 2020, was inspected.

A Critical Incident System inspection #2020_838760_0006 was conducted concurrently with this Complaint inspection.

PLEASE NOTE: A WN related to s. 6 (7), identified in a concurrent inspection #2020_838760_0006 was issued in this report.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Supports Ontario Personal Support Worker (BSO PSW), Housekeepers, Laundry Aides, Director of Clinical Care (DOCC), Housekeeping Manager, Environmental Supervisor, Director of Care (DOC), Administrator, residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) conducted observations, record reviews and interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing
Training and Orientation

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_655679_0030	760

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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received a bath, at a minimum of

twice a week.

The Ministry of Long-Term Care (MLTC) received a complaint from the SDM of resident #003 regarding concerns of the home's short staffing, which resulted in resident #003 not receiving their scheduled baths.

A record review of the home's staffing plan, titled "Nursing- Staffing Contingency Plan- Orchard Villa Long Term Care", indicates that when the home is short of one PSW on a unit, they are to continue to provide scheduled baths to residents.

A review of resident #003's current written plan of care indicated that resident #003 receives their scheduled showers, twice a week. A further record review on the electronic documentation system, Point of Care (POC), indicated the PSW documented the activity did not occur, related to the bathing task on an identified date for resident #003. A review of resident #003's progress notes and chart did not produce information related to why resident #003 did not receive their scheduled bath or whether a bath was given the following day, within the same week.

Record reviews of the staffing schedule on that identified date where resident #003 did not receive their shower indicated that there were four PSWs who worked on that shift and on resident #003's unit.

An interview with RPN #111 indicated resident #003's unit has a regular staffing complement of five PSW and two RPN's. RPN #111 stated that if a bath is missed due to short staffing, a staff member will be brought in either on the next shift or the following day to complete the missed baths. The registered staff will inform the resident's family member and document it in the progress notes afterwards. RPN #111 indicated that if a bath is given on an alternate date, this would be documented on the POC system by the PSW's. RPN #111 confirmed resident #003 received one bath on an identified week.

An interview with DOC #114 indicates that when a unit is short of one PSW, the home's expectations would be to continue to provide care to all residents, as per their plan of care, including providing baths, if they are scheduled on that day. DOC #114 confirmed that the home does experience a shortage of staff. DOC #114 stated that if a bath was given to a resident on an alternate day, the home's expectation would be for the staff to document it on the POC system and a registered staff would communicate this with the resident's SDM and document it afterwards. DOC #114 confirmed that resident #003 did

not receive two baths on an identified week.

The licensee failed to ensure that resident #003 receive a minimum of two baths on an identified week. (760) [s. 33. (1)]

2. Resident #004 was selected for sample expansion related to non-compliance identified related to baths not provided to resident #003.

A record review of resident #004's current written plan of care indicated that they are to receive two baths a week.

A review of the documentation on POC indicated that staff documented the activity did not occur, related to the bathing task on multiple identified dates. A review of resident #004's progress notes and chart did not produce information related to why resident #004 did not receive their scheduled bath or whether a bath was given on an alternate day, during the weeks of those days where they did not receive a bath.

An interview RPN #113 identified that there were some dates where they worked with one less PSW than their regular staffing complement, specific to those dates and shifts where resident #004 did not receive their scheduled bath. However, RPN #113 stated that they seldomly work with a full staffing complement but continue to provide care accordingly to residents, despite having less staff than the usual complement. RPN #113 indicates that if they have one less staff than the regular staffing complement, they are still expected to provide baths to residents, as per their bath schedule.

RN #107 was interviewed and stated resident #004 was supposed to receive two scheduled baths per week. RN #107 stated that on multiple identified weeks, the resident did not receive their two scheduled baths.

An interview with DOC #114 indicated that if resident #004's unit was down one PSW, there would be two RPN's scheduled on the unit to assist, thus the home's expectation would be to continue to provide resident #004 with their scheduled bath. DOC #114 confirmed that resident #004 did not receive two baths on multiple identified weeks.

The licensee failed to ensure that resident #004 received, at a minimum, two baths during multiple identified weeks. (760) [s. 33. (1)]

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations between resident #008 and co-residents in the dining room by implementing interventions.

The MLTC received a complaint from the family member of resident #008 related to various areas of their care including concerns over resident #008's responsive behaviours and how the home manages them. The family member indicated they witnessed an altercation between resident #008 and a co-resident, where resident #008 threw an object at the co-resident, hitting them on an identified body part.

A record review of resident #008's written plan of care identified that they can demonstrate responsive behaviours. There were no interventions identified in resident #008's written plan of care, specific to their responsive behaviours that they demonstrate

during an identified time.

A review of the progress notes for resident #008 indicated they used an object to hit resident #010 on an identified body part. A review of the incident form completed by staff indicate that the responsive behaviours may have been caused by resident #010 triggering resident #008 through an prior interaction.

A review of the progress notes indicates resident #008 was involved in another altercation with resident #009 and threw an object at them. A review of the incident form indicated that staff attempted to move resident #009 away from resident #008 but this did not work which resulted in resident #008's actions.

An interview with the current DOCC #125 (who was the home's previous Behavioural Supports Ontario Registered Practical Nurse) indicated that interventions would be implemented right after an altercation occurs between two co-residents and that a resident's plan of care would be updated to reflect these new interventions. DOCC #125 reviewed resident #008's written plan of care and confirmed that there were no new interventions implemented following these two incidents.

During an interview, DOC #114 indicated that it is the responsibility of staff to ensure that a resident's plan of care becomes updated with interventions following an altercation between two co-residents, in order to prevent a future re-occurrence. DOC #114 reviewed resident #008's plan of care and confirmed that there were no new interventions implemented following these two incidents. DOC #114 and Inspector #760 noted that resident #008's written plan of care was updated with interventions and triggers related to these two incidents, by DOCC #125 after their interview with Inspector #760 and DOC #114 indicated the interventions should have been in place right after these incidents occurred.

The licensee failed to ensure that interventions were implemented to reduce the risk of altercations between resident #008 with resident #009 and resident #010. (760) [s. 54. (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 that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #3: 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 failed to ensure that the care set out in resident #008's plan of care was being provided.

The MLTC received a complaint from the family member of resident #008 related to various areas of their care including the application of fall prevention interventions for the resident.

A record review of resident #008's written plan of care states that staff are to ensure that resident #008 has a fall prevention intervention on at all times due to their risk for falls.

An observation made by Inspector #760 with resident #008 noted they were with PSW #131 and was coming out of a room after receiving care. Resident #008 did not have their fall prevention intervention on at that time. RPN #132 instructed PSW #131 to apply the fall prevention intervention on resident #008 after Inspector #760 was seen observing the resident without it. After the application of the fall prevention intervention, resident #008 did not make any attempts to take it off.

In an interview with PSW #131, they indicated that resident #008 was demonstrating

responsive behaviours earlier in the day and PSW #131 did not ask resident #008 if they wanted their fall prevention intervention applied. PSW #131 confirmed that resident #008 did not have their fall prevention intervention on prior to receiving care that the inspector witnessed them coming out of. RPN #132 stated that resident #008 was supposed to have their fall prevention intervention on at all times except for at bedtime.

An interview with DOC #114 indicated that if a resident's plan of care states that a fall prevention intervention was to be applied at all times, the staff should be applying it for the resident at all times as well. DOC #114 confirmed that resident #008's written plan of care indicates that they should have their fall prevention intervention on at all times and the home's expectations would be for registered staff and PSW's to follow their plan of care at all times. DOC #114 confirmed the home failed to provide the care set out in resident #008's plan of care, as it relates to the application of their fall prevention intervention.

The licensee failed to ensure that resident #008 was provided the care set on in their plan of care, as it relates to the application of their fall prevention intervention. (760) [s. 6. (7)]

2. The licensee failed to ensure that resident #006's care set out in their plan of care was provided.

A Critical Incident Report (CIR) was submitted by the home, related to allegations of staff to resident abuse that occurred in a previous period and was captured by a video camera.

A record review of resident #006's written plan of care around the time of these incidents indicates that the resident required two staff members for assistance due to their responsive behaviours. The written plan of care indicates that staff are to leave resident #006's room if they refuse their care and re-approach afterwards. Furthermore, it states that staff need to assess resident #006's mood before proceeding with their care and report all care refusals to the registered staff and the SDM.

A review of the home's investigation notes indicated PSW #127 acknowledged during the care for resident #006, PSW #127 did not listen to the resident, when they asked for two staff members to be present for their care. PSW #127 indicated that a second PSW was not present during the provision of care to resident #006.

Inspector #760 and DOCC #125 reviewed the video footage from PSW #127 providing care to resident #006 and prior to beginning the care, resident #006 made a gesture to PSW #127. Inspector #760 was unable to hear the communication between the staff members and resident, due to technical issues.

An interview with PSW #116 indicated resident #006 required two staff assistance for care and would ring their call bell if the resident required assistance.

Interview with DOC #114 stated that PSW #127 proceeded to provide care to resident #006, after the resident requested a second staff member to be involved in the care. DOC #114 indicated that in the video, PSW #127 was noted to be speaking to another PSW working that shift and could have gotten that PSW to assist with the resident's care but did not do so.

DOC #114 confirmed the licensee failed to ensure that written plan of care set out for resident #006 was being provided, when PSW #127 provided care to resident #006 without assistance. The plan of care indicated that two staff assistance were required to provide care to resident #006. (760) [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008 was dressed appropriately, in their own clean clothing.

The MLTC received a complaint from the family member of resident #008 related to various areas of their care including concerns that resident #008 was found by their family members wearing stained clothing.

A record review of resident #008's progress notes indicated RPN #133 documented that a PSW reported to them that resident #008 was wearing stained clothing. Resident #008 was changed shortly after it was brought to the staff's attention.

An interview with RPN #133 indicated that they were approached by a PSW at around the start of their shift and saw resident #008 wearing stained clothing. The family member spoke with the PSW and indicated the stain was acquired from the previous shift. RPN #133 confirmed that resident #008 was not dressed in a presentable manner and was not cleaned before the end of the previous shift.

DOC #114 indicated in an interview that the home's expectation would be for staff to clean the resident and ensure if there were stains on their clothing, the staff should have changed their clothing. DOC #114 confirmed the home failed to ensure that resident #008 was dressed appropriately and was wearing clean clothing.

The licensee failed to ensure that resident #008 was dressed appropriately and in clean clothing. (760) [s. 40.]

Issued on this 5th day of June, 2020

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

Original report signed by the inspector.