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
Dec 2, 2020	2020_598570_0013	015654-20, 017646-20, 018136-20	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

SAMI JAROUR (570)

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): November 3, 9, 10, 12, 13, 16, 2020.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

- A log related to follow up to CO #001 issued on July 27, 2020, within inspection report #2020_598570_0006, related to LTCHA, 2007 S.O. 2007, c.8, s. 6. (4).
- Two logs related to allegations of abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Infection Prevention and Control Specialist, Programs Manager and Residents.

During the course of the inspection, the inspector observed the provision of care, resident to resident interactions, staff to residents interactions and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (4)	CO #001	2020_598570_0006	570

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment for its residents related to the failure to screen visitors as specified in Directive #3 regarding screening and number of visitors allowed at a time.

Precautions were implemented for resident #005 as the resident was in close contact with more than two visitors at a time including a visitor who was not screened.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per the version of Directive #3 with effective date of implementation on October 16, 2020, long-term care homes must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19 with the exception of first responders, who should, in emergency situations, be permitted entry without screening. The Directive further directed that residents are permitted up to a maximum of two visitors at a time.

The Director of Care (DOC) acknowledged the incident when resident #005 had more than two visitors at a time and that one of the visitors was not screened.

The lack of adherence to Directive #3 related to the number of visitors allowed at a time and the lack of adherence to screen all visitors presented an actual risk to residents.

Sources: Directive #3 (version effective date October 16, 2020), screening records, progress notes for resident #005, and interviews with the DOC and others. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #002, #003 and #004 were protected from abuse by resident #001.

For the purposes of the Act and Regulation:
Physical abuse is defined as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident

The Ministry of Long-Term Care (MLTC) received two critical incident system (CIS) reports related to allegations of abuse by resident #001 toward residents #002, #003, and #004.

Progress notes for residents #001, #002, #003 and #004 and CIS reports submitted to the MLTC for incidents related to resident #001 indicated that residents #002, #003 and #004 sustained visible injuries by resident #001.

The plan of care for resident #001 identified that the resident had responsive behaviours

and directed staff to look for signs that resident might be getting agitated and to keep co-residents away from resident #001.

The progress notes for resident #001 were reviewed and indicated an intervention was implemented following the incident involving residents #002 and #003. The progress notes did not indicate that the intervention was implemented to resident #001 at the time of incident involving resident #004.

Interviews conducted with RPN #103 and PSW #104 indicated that resident #001's behaviours can be unpredictable and that the resident had not shown any triggers for the incident involving resident #002 and #003.

Interviews conducted with the Director of Care (DOC) and the Assistance Director of Care (ADOC) verified that resident #001 did not have the specified intervention at the time of the incident involving resident #004.

Residents #002, #003, and #004 were not protected from abuse by resident #001.

Sources: Critical Incident System (CIS) reports, clinical records for residents #001, #002, #003 and #004, interviews with the DOC, ADOC, RPN #103, PSW #104 and others. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies for dealing with resident #001's responsive behaviours were implemented.

The Ministry of Long-Term Care (MLTC) received critical incident system (CIS) report related to allegations of abuse by resident #001 toward resident #004.

The CIS report and progress notes for residents #001 and #004 indicated that resident #004 sustained an injury caused by resident #001.

The plan of care for resident #001 identified that the resident had responsive behaviours directed staff to look for signs that resident #001 might be getting agitated and to keep co-residents away from the resident.

The progress notes for resident #001 were reviewed and indicated the specified intervention was implemented following incident involving residents #002 and #003. The progress notes did not indicate that the interventions was implemented for resident #001 at the time of the incident involving resident #004.

Interviews conducted with the Director of Care (DOC) and the Assistance Director of Care (ADOC) verified that resident #001 did not have the specified intervention at the time of the incident involving resident #004.

Resident #004 sustained an injury and other residents were at risk of harm when a specified intervention was not implemented to manage resident #001's responsive behaviours.

Sources: Critical Incident System (CIS) report, clinical records for residents #001 and #004, interviews with the DOC, ADOC, RPN #103, PSW #104 and others. [s. 53. (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 strategies are developed and implemented for each resident demonstrating responsive behaviours, to be implemented voluntarily.

Issued on this 4th day of December, 2020

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

Original report signed by the inspector.