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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2021	2021_882760_0022	007419-21, 007421-21, 007713-21	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

JACK SHI (760), SUSAN SEMEREDY (501)

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): June 22, 23, 24, 25, 2021.

The following intakes were completed in this critical incident inspection:

A log related to a fall;
A follow up log to Compliance Order (CO) #001, O. Reg 79/10 s. 229 (4), related to infection prevention and control, issued under inspection #2021_643111_0008, on April 30, 2021, with a compliance date of May 31, 2021;
A follow up log to Compliance Order (CO) #002, LTCHA s. 5, related to safe and secure home, issued under inspection #2021_643111_0008, on April 30, 2021, with a compliance date of May 31, 2021.

During the course of the inspection, the inspector(s) spoke with Infection Control and Control (IPAC) Specialist, contractors, Dietary Aides, the Social Worker, housekeepers, Food service and Nutrition Manager, visitors, residents, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the Director of Care (DOC).

During the course of the inspection, the inspectors observed resident and staff interactions, the provision of care and infection prevention and control practices. Inspectors also reviewed clinical health records, relevant home policies and procedures, temperature monitoring logs other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 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. 5.	CO #002	2021_643111_0008	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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection #2021_643111_0008 issued on April 30, 2021, with a compliance due date of May 31,

2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff along with visitors and contractors continued to be noncompliant with the implementation of the home's IPAC program.

Observations were carried throughout the home during this inspection:
- A PSW was observed to be talking to a resident and was not wearing any eye protection. The IPAC specialist stated the PSW should have worn eye protection.
- A visitor was observed without wearing a mask while they were with a resident. The IPAC specialist stated that the visitor was supposed to wear a surgical mask when they were with the resident.
- A PSW was observed applying two pairs of gloves prior to entering a resident room. The IPAC specialist stated that it is not part of the home’s practice to put two pairs of gloves on.
- A contractor was observed going in and out of a resident room on precautions without wearing the appropriate personal protective equipment (PPE). The contractor was later seen wearing the same gown while entering several different resident rooms.
- A dietary aide (DA) was observed with their soiled gloves on while they entered a hallway area. The IPAC specialist stated that the DA should have doffed their gloves after finishing their task and should not have kept it on while they entered the hallway.
- A housekeeper was observed without their mask covering their nose. The IPAC specialist stated that all staff are expected to have their mask cover their nose and mouth and the nose piece should be tightened so it does not fall off.
- Another DA was observed without their eye protection on while residents were nearby. The IPAC specialist stated that staff were expected to wear eye protection at all times when in resident areas.
- A PSW was seen donning a gown in the hallway, far from the resident’s room and did not put on gloves prior to entering a resident’s room with precautions. The PSW discarded their PPE in a waste disposal in the hallway and did not change their mask or clean their eye protection. The PSW was seen with multiple disposable gloves in their pockets that was kept with their keys and name tag. At another time, the same PSW dropped their gown onto the floor while donning it and continued to use that same gown to enter the resident’s room. When the PSW exited the resident’s room, they disposed their mask outside of the room and continued to walk in the hallway for a distance to obtain a new mask in a PPE caddie located far away from the resident’s room. The IPAC

specialist stated that the PPE should be discarded inside the resident's room, face shields should be cleaned and the mask should be changed after exiting the resident's room, PPE should be donned in front of the resident's room and use a cart or trolley to allow the PSW to have donned and doffed their PPE properly.
- A Maintenance Worker (MW) was seen going into a resident's room with precautions without donning any PPE until the Social Worker (SW) reminded them of the need to do so. The MW was noted to not have been wearing any eye protection while they entered the resident's room. The MW was also seen using their work gloves when they went into the resident's room but did not sanitize their work gloves after coming out of the resident's room. The IPAC specialist stated that the MW should sanitize their work gloves after coming out of a resident room with precautions and should have been wearing eye protection when in a resident home area.
- The SW was seen doffing their PPE after coming out of a resident's room with precautions but did not clean their eye protection.
- A visitor was seen going into a resident's room with precautions without donning any PPE. The IPAC specialist stated that the visitor should have worn the appropriate PPE prior to entering the resident's room.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff, contractors and visitors of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the IPAC Specialist and other staff; Observations made throughout the home during the inspection. [s. 229. (4)]

Additional Required Actions:

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

WN #2: 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 a resident's plan of care was provided related to the food they were served.

An observation demonstrated that a resident received a type of food. The resident stated that they were allergic to this food and did not consume it. A review of the resident's plan of care confirmed their allergy. The Food Service and Nutrition Manager stated that the resident should not have been served food they were allergic to and the staff should have followed up by checking what they serve. By failing to ensure that this resident received their food in accordance to their diet, there was a potential risk of the resident having an allergic reaction.

Sources: An observation on the resident unit; Review of a resident's plan of care; Interviews with the resident, the Food Service and Nutrition Manager and other staff. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature was measured and documented in every designated cooling area between a period in May 2021 to June 2021.

A review of the home's air temperature monitoring logs indicated that between a period in May 2021 to June 2021, the air temperature was taken in the designated cooling areas in the home and listed two resident rooms. The inspector noted that there were no additional spaces to add the air temperature in the resident rooms on the log. The Environmental Services Manager (ESM) clarified that on the days that the air temperature was taken on two resident rooms in a unit of the home, the designated cooling area on that unit would not have their air temperature taken. Failure to monitor the air temperatures in designated cooling areas of the home may result in uncomfortable temperatures for residents who would be in that designated cooling area.

Sources: Review of the home's air temperature monitoring logs from May 2021 to June 2021; Interview with the ESM and other staff. [s. 21. (2) 3.]

Issued on this 6th day of July, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JACK SHI (760), SUSAN SEMEREDY (501)
Inspection No. / No de l’inspection :	2021_882760_0022
Log No. / No de registre :	007419-21, 007421-21, 007713-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 29, 2021
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 :	Jason Gay

Ontario

Ministry of Long-Term Care

Ministère 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

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(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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_643111_0008, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff, visitors and contractors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff, contractors and/or visitors not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection #2021_643111_0008 issued on April 30, 2021, with a compliance due date of May 31, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff along with visitors and contractors continued to be noncompliant with the implementation of the home's IPAC program.

Observations were carried throughout the home during this inspection:
- A PSW was observed to be talking to a resident and was not wearing any eye protection. The IPAC specialist stated the PSW should have worn eye

protection.
- A visitor was observed without wearing a mask while they were with a resident. The IPAC specialist stated that the visitor was supposed to wear a surgical mask when they were with the resident.
- A PSW was observed applying two pairs of gloves prior to entering a resident room. The IPAC specialist stated that it is not part of the home's practice to put two pairs of gloves on.
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precautions without donning any PPE until the Social Worker (SW) reminded them of the need to do so. The MW was noted to not have been wearing any eye protection while they entered the resident's room. The MW was also seen using their work gloves when they went into the resident's room but did not sanitize their work gloves after coming out of the resident's room. The IPAC specialist stated that the MW should sanitize their work gloves after coming out of a resident room with precautions and should have been wearing eye protection when in a resident home area.
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The observations demonstrated that there were inconsistent IPAC practices performed by the staff, contractors and visitors of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the IPAC Specialist and other staff; Observations made throughout the home during the inspection.

Severity: There was actual risk of harm to the residents because staff, visitors and contractors of the home continued to be non-compliant with the proper IPAC measures, which may possibly lead to the spread of infectious diseases.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO #001 was issued on April 30, 2021, (Inspection 2021_643111_0008) with a compliance due date of May 31, 2021. In addition, the home has had non-compliance to the same subsection in the past 36 months as follows:

-issued a Voluntary Plan of Correction (VPC) on October 28, 2020 during inspection #2020_603194_0016.
-issued a Voluntary Plan of Correction (VPC) on July 27, 2020 during inspection #2020_598570_0006. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 26, 2021

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 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 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 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 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 29th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

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