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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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
Mar 16, 2022	2022_927957_0010	002862-22	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

CATHERINE OCHNIK (704957)

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): March 10 and 11, 2022.

The following intake was completed in this Critical Incident Inspection, related to alleged staff to resident abuse.

During the course of the inspection the inspector toured the home, observed residents, resident rooms and common areas, reviewed health care records, plans of care for identified residents, home policies and procedures, investigation notes, and other pertinent documents.

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), a Physician, Durham Regional Police Services Detectives, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect staff to resident abuse of resident #001, which resulted in harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date, Registered Practical Nurse (RPN) #104 rushed to resident #001's room after Personal Support Worker (PSW) #105 called out for help. While both staff members were present in the room, resident #001 made an allegation of staff to resident abuse against PSW #105. Resident #001 was sent to hospital, and it was discovered that they had sustained an injury.

The CIS Report indicated that the allegation of staff to resident abuse toward resident #001 was reported to the Ministry of Long-Term Care on a specified date. Clinical record review showed that the incident had occurred at an earlier date.

Orchard Villa's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) Last Updated June 2021 states on page 4 that "any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time. Note: In Ontario, in addition to the above, anyone who

suspects or witnesses abuse, incompetent care or treatment of a resident, misappropriation of funds (resident or funds provided to the licensee under the LTCHA or the Local Health Systems Integration Act), and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through the Action Line and is protected by legislation (Whistleblower's protection) from retaliation."

In an interview, RPN #104 acknowledged that they did not report the allegation of abuse made by resident #001 to the Ministry of Long-Term Care.

During an interview, the Director of Care (DOC #100) verified that the allegation of abuse made by resident #001 was not reported to the Ministry of Long Term Care immediately.

Sources: CIS Report #2693-000006-22, Orchard Villa's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) Last Updated June 2021, the home's investigation notes, resident #001's progress notes, interviews with RPN #104 and DOC #100. [s. 24. (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 allegations of staff to resident abuse are reported to the director immediately., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged incident of abuse of resident #001 that the licensee suspected may have constituted as a criminal offence.

CIS Report indicated that an allegation of staff to resident abuse toward resident #001, which resulted in resident #001 sustaining an injury, was reported to the Durham Regional Police Service (DRPS) on a specified date.

In an interview, RPN #104 acknowledged that they did not immediately report the allegation of abuse made by resident #001 to police.

During an interview, the DOC #100 verified that the allegation of abuse made by resident #001 was not reported to DRPS immediately.

Sources: CIS Report #2693-000006-22, the home’s investigation notes, resident #001’s progress notes, interviews with Detective #110, RPN #104 and DOC #100. [s. 98.]

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 appropriate police force is immediately notified of any alleged or suspected incident of abuse of a resident that the licensee suspects may constitute a criminal offense., to be implemented voluntarily.

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Issued on this 16th day of March, 2022

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

Original report signed by the inspector.