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
Mar 10, 2022	2022_861194_0003	002504-22	Proactive Compliance Inspection

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

CHANTAL LAFRENIERE (194), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): February 23, 24, 25, 28, March 1, 2, 3, 4, 7, 2022

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Maker (SDM) of identified residents, Presidents of Resident and Family Councils, Executive Director (ED), Director of Care (DOC), Director of Clinical Care (DCC),Clinical Manager, Vice President of Infection Prevention and Control, Infection Prevention and Control (IPAC) lead, Regional Clinical Coordinator, Program Manager, Social Worker, Senior Public Health Inspector, Nutrition Manager, Dietary Aide, Director of Clinical Support, Senior Executive Director, Registered Nurse (RN), Registered Practical Nurse (RPN) Personal Support Worker (PSW), Housekeeping Staff, COVID-19 Tester and Screener.

During the course of the inspection the inspectors observed staff to resident provision of care, toured the home, observed IPAC practices, dining service and medication administration. The inspectors reviewed the relevant IPAC, medication, dietary, Skin and Wound, Falls, Pain and Resident abuse Policy/Programs. The inspectors reviewed clinical health records of identified residents, Resident Council Minutes, Family Council Minutes, Quality Improvement evaluation and Resident/Family satisfaction survey and action plan.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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)**

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 failed to ensure that the care set out in the plan of care for a resident was provided as specified.

The plan of care for a resident confirmed that fall interventions and an assistive aide were to be in place.

The resident was observed with no fall interventions and no assistive aide in place. A PSW confirmed that the falls intervention should have been in place, stating that the resident did not have an assistive aide. The resident was observed a second time, with no falls interventions or assistive aide. Another PSW confirmed that the falls intervention should have been in place, but stated there were no assistive aide for the resident. Physio Therapist (PT) #141 confirmed that the resident's assistive aide was still active. The resident was observed a third time, with no assistive aide. Failing to provide the care set out in the plan of care as specified, increases the risk of harm to the resident.

Source: observation of the resident, review of residents clinical health records, Interview with resident and staff. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents.

During dining observations residents were observed to have uneaten food on their plates. Interviews were conducted with residents for food satisfaction. Residents indicated that the soup and the main meal were cold when served.

Review of the pre-meal service temperature log indicated the food was within the acceptable range and the homes policies for food temperatures.

Interview with a Dietary Aid and Nutrition Manager (NM) indicated that food temperatures were to be taken prior to the start of the meal service. While the Inspector was observing, the NM took the food temperatures from the steam table. The main meal was below the acceptable range as per the homes policy. NM indicated that the serving dish for the main meal was not placed directly in the steam table.

Review of the Food Committee meeting minutes for 2021 identified several complaints from residents about the temperature of food being served.

When the serving dish was not correctly placed into the steam table to maintain the temperature, residents were at risk of receiving food that was served at a temperature that was unsafe and not palatable.

Sources: observations, resident interviews, interview with DA and NM, End Point Food Temperature & Appendix 1 – End Point Cooking Temperature Chart. [s. 73. (1) 6.]

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 by ensuring that food and fluids are being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #3: 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. The Licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program (IPAC).

The homes “PPE guide” directed that staff were to apply PPE correctly before entering a room with additional precautions and staff were to remove the PPE in a sequence that prevents self-contamination. Putting it on and removing of PPE posters were noted on several resident rooms. The guide directed the use of signage for Aerosol generating medical procedure (AGMP) use at the home. Review of the contact precautions and droplet precaution policies directed that signage was to be placed outside the resident room for additional precaution. Interview with IPAC lead and Regional Clinical Coordinator confirmed the home's application of the PPE guide.

An RPN confirmed that two residents were using an AGMP at the home, there was no precaution signage or PPE's available at one resident’s room, and no N95 masks available at the other resident's PPE caddy.

An RPN confirmed that a resident was under droplet and contact precautions with use of N95 mask. There were no N95 masks available in the PPE caddy . Another resident's room was observed to have signage for droplet and contact precautions with N95 to be

worn, there were no N95 available for staff in the PPE caddy.

Multiple residents' in semi-private rooms were observed to have a contact precaution sign with PPE caddy in place. The signage did not indicate for which resident the additional precautions were for. A PSW confirmed that they would use the PPE for both residents as it was not identified who the precautions were used for. PSW stated that at times the additional precautions were discussed at report, or a co-worker might say “stop” then you would know not to go in without equipment. The PSW stated that they could ask the nurse but would be told to review the plan of care.

IPAC #102 confirmed that two residents were under contact precautions, there were no contact precaution signs or PPEs readily available. An RPN confirmed that a resident was under droplet and contact precautions with N95 precautions, there were no N95 masks available in the PPE caddy. A Housekeeper (HSKP) was observed improperly putting on PPE prior to entering the room. The HSKP was observed exiting the room to obtain equipment off the housekeeping cart in the hallway, without removing and reapplying PPEs. Upon exiting the room the HSKP removed the gown, then walked away with gloves, face shield and N95 mask in place. A PSW was observed sitting outside the resident’s room wearing full PPE and N95 mask. The PSW entered the resident room to redirect the resident. The PSW then returned to sit in the chair outside the resident’s room, without having cleaned or discarded their face shield and or changing their mask.

Two Housekeepers (HSKP) were observed cleaning isolation rooms. One room was under droplet and contact precautions with N95 signage at the door and the other room was under droplet and contact precautions without N95 signage on the door. The first HSKP was observed exiting the isolation room taking off PPE’s and reapplying gloves. The HSKP picked up the garbage bag from the floor in room, holding it against their uniform, exiting the room, to the soiled utility room. The Housekeeper's mask and shield were not removed or changed. When exiting the room the second HSKP, removed their PPE’s but their surgical mask and shield were not changed. There was no N95 mask used. At the doorway to room the second HSKP cleaned their hands and put on their gown. They entered the room without changing their mask or shield. The same was observed with the garbage bag touching their uniform after removing their gown. The first HSKP informed inspector #623 that they did not need to remove their mask and shield when leaving an isolation room, stating that they changed it before entering the next room. The HSKP stated that they did not require to wear a gown when carrying garbage out of an isolation room, where the garbage was touching their uniform. The HSKP

stated that they were wearing the same mask and shield for both isolation rooms, stating they did not know they needed to change them. The HSKP confirmed that they did not wear and N95 while cleaning the isolation room, stating that they did not need to wear them anymore. The HSKP stated that they used the same cleaning cloth from room to room and that this was ok, as the solution was a disinfectant. Failing to ensure that staff participate in the implementation of the IPAC program, increases the risk of transmission of infection.

Source: Observation of residents with additional precautions in place, Review of the homes PPE Guide, interview with staff. [s. 229. (4)]

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 by ensuring that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

Issued on this 24th day of March, 2022

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

Original report signed by the inspector.