Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 8, 2022
Inspection Number [2022_1193_0001]
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
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.)
Long-Term Care Home and City
Orchard Villa, Pickering

Lead Inspector
Sami Jarour (570)

Additional Inspector(s)
Catherine Ochnik (704957)

Inspector Digital Signature
Sami Jarour
2022.06.08 14:41:26 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 4, 5, 9, 10, 11, 12 and 13, 2022.

The following intake(s) were inspected:

- Log #016398-21 related to a fall incident.
- Log #017489-21 related to an allegation of abuse.
- Log #018164-21 related to a fall incident.
- Log #001546-22 related to failure/breakdown of ventilation system (heating).
- Log #001673-22 related to an allegation of abuse.
- Log #006715-22 related to a fall incident.
- Log #008302-22 related to a fall incident.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Falls Prevention and Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Safe and Secure Home

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INSPECTION RESULTS

WRITTEN NOTIFICATION - REPORTING CERTAIN MATTERS TO DIRECTOR

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 [s. 24. (1)]

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) indicated an allegation of abuse by a co resident toward resident #008 was not immediately reported to the Director.

A review of progress notes for resident #008 indicated the resident reported the allegation to registered nurse (RN) #110 four days prior the submission of the CIR.

Interview with RN #110 confirmed that they did not report the incident.

Interview with the DOC acknowledged the late reporting of the incident and indicated the incident should have been immediately reported to the MLTC when it was reported by the resident.

Sources: Critical Incident Report (CIR), resident #008's health records, and interviews with the RN #110 and the DOC. [570]

WRITTEN NOTIFICATION - AIR TEMPERATURE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s. 21. (1)*

The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to failure of the home's heating, ventilation, and air conditioning (HVAC) system. On the date of the incident, the CIR indicated air temperatures on two residents' home areas started to gradually fluctuate below 22 degrees Celsius.

A review of the home's temperature logs for the month of January 2022, indicated air temperatures in the home dropped below 22 degrees Celsius on the date of the incident in three residents' home areas.

Interview the Executive Director (ED) acknowledged air temperatures fluctuated below 22 degrees Celsius on the date of the incident.

Sources: Critical Incident Report (CIR), air temperatures logs, and interview with the Executive Director (ED). [570]

COMPLIANCE ORDER CO#001 PLAN OF CARE

NC#003 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 6. (2)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order - FLTCA 2021, s. 155. (1) (a)

The Licensee has failed to comply with s. 6. (2) of the FLTCA.

Specifically, the licensee shall:

1. Educate registered staff in one residents' home area regarding the home's process for updating resident care plans with interventions based on resident's post falls assessment.

2. Keep a record of the content of this training, the date the training was provided, the person conducting the training and those that attended.

Grounds

Non-compliance with: FLTCA, 2021 s. 6. (2)

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The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Ministry of Long-Term Care (MLTC) indicated that resident #004 sustained a fall with injury. The resident was transferred to hospital and returned with a specified diagnosis and was placed on palliative care. The resident passed away four days after returning from hospital.

Progress notes review indicated that resident #004 had a previous fall and a post falls assessment completed indicated that having universal falls precautions could have prevented the fall from taking place.

Resident #004's plan of care reviewed post previous fall, indicated that they were at a risk of falls. Interventions in the plan of care included specified interventions for falls.

In an interview, Associate Director of Operations and Clinical Support (ADOCS) acknowledged that falls interventions noted in the post falls assessment should have been specific to the resident and that the care plan should have been updated to reflect those changes from the post falls assessment.

A post falls assessment completed for resident #004's second fall indicated two specified interventions that would be added to the resident's care plan.

Resident #004's care plan, indicated that they were at a risk of falls. Interventions in the care plan included specified falls prevention intervention but did not include the two specified interventions.

In an interview, RN #119 acknowledged that falls interventions for resident #004 were not adequate.

The home's Falls Prevention and Management Program Policy (RC-15-01-01) Appendix 2 - Fall Risk Assessment Tool (AB, SK, ON) Last Updated: August 2019 (RC-15-01-01) A2 indicates that a high Morse fall risk score action is to implement resident-specific Fall Prevention interventions.

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As a result of resident #004's plan of care not being based on the post falls assessment completed on January 24, 2022, there was actual harm to resident #004, as they died as a result of the injury sustained from the fall.

Sources: Critical Incident Report , the home's "Falls Prevention and Management Program Policy" (RC-15-01-01) policy Appendix 2 - Fall Risk Assessment Tool (AB, SK, ON) Last Updated: August 2019 (RC-15-01-01) A2, resident #004's progress notes, clinical record review, interviews with ADOCS and RN #119. [704957]

This order must be complied with by July 6, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.