Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: November 3, 2023
Inspection Number: 2023-1193-0007
Inspection Type: Complaint Critical Incident
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Orchard Villa, Pickering

Lead Inspector	**Inspector Digital Signature**
Chantal Lafreniere (194)	Chantal D Lafreniere Digitally signed by Chantal D Lafreniere Date: 2023.11.06 14:51:22 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 17- 19, 23- 25, 2023.

The following intake(s) were inspected:

- Critical Incident Report (CI) related to improper care of a resident.
- Complaint related to resident care.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1)

The licensee failed to immediately forward to the Director, a written complaint about the care of a resident.

RATIONALE and SUMMARY:

The Director of Care (DOC) confirmed receiving an email from the family of a resident, outlining concerns about the care of the residents.

The DOC confirmed that the written complaint about the care of a resident was submitted to the Director six days later.

Failing to immediately forward the written complaint about the care of a resident had little impact on the resident.

Sources: Complaint letter and response letter, Interview with staff. [194]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee failed to provide resident with tables/trays, required to safely eat and drink as comfortably and independently as possible, while in isolation in their rooms.

RATIONALE and SUMMARY:

During a meal service it was observed that a number of resident isolated to their rooms did not have tables for them to eat at when meals were being provided.

A resident was observed eating their meal, out of a Styrofoam container on their lap, while sitting in their lounge chair in their room.

Another resident was observed eating their meal, out of a Styrofoam container on their lap, while sitting in their lounge chair in their room.

Another resident was observed eating their meal, out of a Styrofoam container with the tray sitting on their bed.

An RPN was asked why the residents did not have tables, they replied that they would have to look to see if they had any.

The ED confirmed that the residents should have been provided tables to eat their meals, while in isolation.

Failing to ensure that residents in isolation were provided tables/trays to safely consume their meals, increased the risk of injury for the residents.

Sources: Observations of lunch meal service on a unit, Interview with staff. [194]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

The licensee failed to ensure that a resident who required assistance with eating or drinking was not served a meal until someone was available to provide the assistance required by the resident.

RATIONALE and SUMMARY:

During an observation of a lunch meal, PSW's were observed delivering meal trays to the resident rooms.

A resident was observed lying on their bed when a PSW delivered the lunch meal tray and placed in on the dresser drawer at the end of the resident's bed.

The resident was observed remaining on their bed. No staff entered the room to assist the resident with

their meal. A PSW entered the room and brought the meal tray over to the resident's bedside and began to assist the resident with their meal, 15 minutes after it had been delivered.

Review of the resident's plan of care indicated that the resident required extensive assistance of one staff to feed or encourage the resident to feed themselves.

Failing to ensure that the resident was provided assistance with eating and drinking when the meal was served minimized the enjoyment of the meal.

Source: Observation of the lunch meal, review of the clinical health record for a resident. [194]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee failed to provide the family of a resident, a response which included the Ministry's toll-free telephone number for making complaints about the home.

RATIONALE and SUMMARY:

A resident's family provided the home with a written complaint related to the resident's care and maintenance required in the resident's room. The resident's family confirmed that they had not been provided a response for the status of the maintenance of the room.

The Environmental Services Manager (ESM) confirmed that a work order had been submitted for the maintenance of the room and that the issue had been resolved.

The Social Worker (SW) confirmed that two weeks after the original complaint related to the maintenance in the resident's room, the family was in the home and wanted to know why the maintenance to the room had not been completed. The SW indicated that a Maintenance person was sent to the room to investigate and reported that the issue could not be fixed and would have to be replaced.

The ED confirmed that they had been advised of the situation on the following business day, at the home management meeting and was informed by the ESM that the situation had been resolved.

The ED, ESM and SW all verified that they had not contacted the family of the resident to provide an explanation of the repairs related to the maintenance to the resident's room.

Failing to provide the family with a response to the complaint which included the Ministry's toll-free telephone number for making complaints, limits the family's ability to escalate their concerns.

Sources: Review of the family's e-mail, Maintenance Care report, Internal complaint form, observation of the resident's room, interview with staff. [194]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee failed to provide the resident's family with an explanation of what the licensee has done to resolve the concern related to maintenance in the resident's room.

RATIONALE and SUMMARY:

The resident's family provided the home with a written complaint related to the resident's care and maintenance to the resident's room. The resident's family confirmed that they had not been provided a response for the status of the maintenance to the room.

Social Worker (SW) confirmed that they received an email from the resident's family listing concerns related to the resident's care. The SW confirmed that they initiated a complaint form for the concern expressed by the family in the email. The Social Worker confirmed that they had not informed the complainant of the outcome of the complaint received, related to the maintenance to the resident's room. SW confirmed that they had logged the request for maintenance into the Maintenance Care system to have the issue repaired. SW stated that they had followed up with the Maintenance care report and was informed that the issue had been repaired. The SW indicated that two weeks later the Nursing supervisor informed them that the family had been in and were upset that the maintenance to the resident's room were not completed. The SW indicated that they called maintenance staff to go to the room to see what could be done, the maintenance staff informed them that the issue could not be fixed that day and that new parts would be required. The SW indicated that they brought the concern forward the following business day, at the Risk Management Meeting.

The Environmental Services Manager (ESM) confirmed that they were aware that a concern had been

logged into the "Maintenance care" system at the home. The ESM indicated that they were not involved in resolving the issue as it was undertaken by the ESS. ESM confirmed that they had not contacted the family with the outcome of their complaint.

Environmental Services Supervisor (ESS) confirmed that they had delegated the task to the "Handy Person" at the home and that the issue had been repaired. The ESS confirmed that they had not contacted the family with the outcome of their complaint.

Executive Director confirmed that they had been informed of the complaint recently at the Daily Risk Management meetings held with managers at the home. ED indicated that the ESM confirmed the concern had been resolved. ED confirmed that they did not contact the family with the outcome of their complaint.

The resident's family confirmed that they had not been provided an update as to the current status with the maintenance in the resident's room.

Failing to provide a response which included an explanation of what the licensee has done to resolve the complaint, increases the risk of miscommunication at the home.

Sources: Review of the families e-mail, Maintenance Care report, Internal complaint form, observation of the residents room, interview with staff. [194]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for the actions to be taken and any follow up action required.

RATIONALE and SUMMARY:

1. A complaint letter was received from a resident's family identifying concerns related to the resident's care.

Review of the home's complaint binder was completed, with no evidence of the type of action taken to

resolve, some of the items identified in the concern, including the date of the action, time frames for the actions to be taken and any follow up action required.

Failing to ensure that a documented record of the written complaint was kept at the home decreases the home's ability to analyze the homes complaints.

Sources: The home's complaint log records, complaint letter and response letter and interview with staff. [194]

2. The resident's family spoke to the nursing supervisor reporting that the maintenance to the resident's bedroom was not completed. The Nursing Supervisor forwarded the concern to the on-call manager who was the Social Worker (SW). The SW forwarded the information to the Maintenance department and was informed that the issue could not be repaired and would have to be replaced. Review of the Maintenance Care system was completed, and no work order was initiated for the work completed the second time. The Environmental Service Manager (ESM) was not aware that there was any further action required after the initial work order showing being completed. Review of the complaint binder at the home did not have any documentation of the second complaint received by Nursing supervisor related to the ongoing maintenance issue in the resident's room.

Failing to ensure that a documented record of the complaint was kept at the home, delays the homes ability to manage the complaints in a timely manner.

Sources: Review of the home Maintenance Care System, Complaint binder and interview with staff. [194]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee failed to ensure that a documented record of the written complaint is kept in the home that includes the final resolution.

RATIONALE and SUMMARY:

1. A complaint letter was received from a resident's family identifying concerns related to care of the resident.

A response letter was provided to the resident's family and submitted to the Director. The response letter stated that a meeting was held with family to discuss all the concerns and interventions in place as well as all the meetings that had taken place with staff. The response letter discussed items not mentioned in the complaint letter. The complaint letter did not provide a final resolution for some of the concerns related to the resident's care.

The DOC confirmed that a telephone call and meeting was scheduled with family to discuss concerns identified in the complaint letter. The DOC confirmed that the response letter submitted to the Director did not provide a final resolution to all the identified concerns.

Failing to ensure that documented record of the written complaint is kept at the home that includes the final resolution increases the risk of the situation re occurring at the home.

Sources: Complaint letter, response letter and interview with staff. (DOC). [194]

2. A resident family spoke to the nursing supervisor reporting that the maintenance in the resident's bedroom was not completed. The Nursing Supervisor forwarded the concern to the on-call manager who was the Social Worker (SW). The SW forwarded the information to the Maintenance department and was informed that the issue could not be repaired and would have to be replaced. Review of the Maintenance Care system was completed, and no work order was initiated for the work completed the second time. The Environmental Service Manager (ESM) was not aware that there was any further action required after the initial work order showing being completed. Review of the complaint binder at the home did not have any documentation of the second complaint received by Nursing supervisor related to the ongoing maintenance in the residents room.

Failing to ensure that a documented record of the final resolution to a complaint was kept at the home, delays the homes ability to manage the complaints in a timely manner.

Sources: Review of the home Maintenance Care System, Complaint binder and interview with staff. [194]