Long-Term Care Operations Division
Regulatory Compliance Branch

Regulatory Compliance Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

Order of the Director Public Report Cover Sheet

Date of the Order: June 28, 2023	
Director Order Number: DO #001	
Inspection Number: 2023-1193-0004	
Order Type: Compliance Order s. 155 (1)	
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	
Issued By Tammy Szymanowski (165)	**Director Digital Signature** Tammy Szymanowski

ORDER OF THE DIRECTOR SUMMARY

The Licensee requested the Director to review the inspector's order and AMP pursuant to s. 169 of the FLTCA. I found that s. 54(2) did not address the inaction and seriousness of the non-compliance and as a result, the inspector's order is altered and substituted with the following order of the Director. The order below is issued to address the licensee's non-compliance with s. 24(1) of the FLTCA for not ensuring the home protected a resident from neglect by staff.

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Background

An inspection was conducted at Orchard Villa (the Home) between April 3-6, 11-14, 2023. An inspector found that the Licensee, CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.) (Licensee), did not comply with s.54(2) of the Regulation, under the Fixing Long-Term Care Act, 2021 (FL TCA). The inspector issued a compliance order and associated administrative monetary penalty (AMP) for the non-compliance finding. The Licensee requested the Director to review the inspector's order and AMP pursuant to s. 169 of the FLTCA. I found that s. 54(2) did not address the inaction and seriousness of the non-compliance and as a result, the inspector's order is altered and substituted with the following order of the Director. The order below is issued to address the licensee's non-compliance with s. 24(1) of the FLTCA for not ensuring that the home protected resident #012 from neglect by staff.

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Order: DO #001

To CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.), you are hereby required to comply with the following order by the date(s) set out below:

Pursuant to

Order pursuant to FLTCA, 2021, s.155 (1)
Non-compliance with: FLTCA, 2021, s. 24 (1)

Order

24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.), ('the licensee') is ordered:

1. Develop and implement an auditing process to ensure the post-fall clinical pathway, is implemented by staff for residents who have fallen. Keep a written record of the completed audits, dates, person completing, and actions taken to correct any deficiencies. The auditing process must continue for a minimum two weeks or until such time you are satisfied you have returned to compliance.
2. Review and evaluate the effectiveness of your current zero tolerance of abuse and neglect training specifically related to neglect and consider if including a case study of neglect such as this would enhance the awareness and learning of staff. Keep a written record of your evaluation.

Grounds

The Licensee failed to ensure that the home protected a resident from neglect by a Personal Support

Worker (PSW) and a Registered Practical Nurse (RPN).

Rationale and Summary:
For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A PSW and RPN entered a resident's room and found the resident on the floor.
The Licensee has a Falls Prevention and Management Program that directs registered staff to implement a post-fall clinical pathway which includes a focused assessment by the first registered staff person on the scene which would then require a clinical decision prior to moving the resident. Assessment(s) are to be conducted immediately at the time (when) the resident has fallen and prior to movement of the resident. Despite being the first registered staff to the scene, the RPN did not conduct a focused assessment, including neurological and physical elements, in order to make the required clinical decision prior to moving the resident. Without assessment, the RPN and PSW transferred the resident back to bed without using a mechanical lift. In addition to not following the transfer guidance outlined in the falls program, they chose not to follow the resident's plan of care as it relates to transfers which also states the resident required extensive assistance of two staff using a sit to stand mechanical lift.

Once the resident was transferred back to bed, the RPN also failed to reassess the resident for injuries or pain nor provided any comfort or treatment to the resident.

As outlined in the Home's clinical pathway, the RPN did not consider a possible head/brain injury, fracture or other injury, any possibility of delayed complications or if the resident was on specific medications which would effect the resident post fall, even after the PSW showed the RPN evidence of injury three hours later. When the RPN was shown the injury, they asked the PSW not to report the fall because they were aware of their inactions and the failure to provide the required care and assistance related to the transfer at the time it occurred. The RPN did not initiate clinical monitoring despite the resident experiencing an unwitnessed fall.

The clinical pathway also requires registered staff to complete additional documentation on incident report/risk management, post fall assessment, review the resident's fall risk level, review and update the resident's plan of care, document in the interdisciplinary progress notes and make referrals to the interdisciplinary team members. The RPN did not complete any of these procedures. In fact, the RPN did not communicate to on-coming staff verbally or through documentation that the resident sustained a fall at all. The RPN knew that the appropriate step was to complete a post fall assessment but took overt steps to avoid it. The RPN chose not to implement nor complete any of the steps outlined in the Home's Fall Prevention and Management Program.

The resident was neglected when the PSW and the RPN failed to provide the required treatment, care, assistance and demonstrated a pattern of inaction. Which not only included failing to complete a post fall assessment, but it also included, failing to assess the resident prior to transferring, implementing the post fall clinical pathway, reporting the fall to on-coming staff and not providing the required care related to physically transferring the resident. The resident had an unwitnessed fall with visible signs of injury to their head and was prescribed specific medication daily. Despite this, the RPN advertently chose not to implement the post fall clinical pathway or any component of the Fall Prevention and Management Program and as a result, it was at least six hours until the resident received a neurological and physical assessment (by the next shifts RPN) putting them at increased risk of harm. The resident had sustained injury.

This order must be complied with by: July 7, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

Pursuant to s. 170 of the Fixing Long-term Care Act, 2021 the licensee has the right to appeal any of the following to Health Service Appeal Review Board (HSARB):

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

(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
Regulatory Compliance 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.