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
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Original Public Report

Report Issue Date: Thursday, January 18, 2024
Inspection Number: 2023-1193-0008
Inspection Type: 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**
Michael Chan (000708)	Michael K Chan Digitally signed by Michael K Chan Date: 2024.01.31 13:39:03 -05'00'

Additional Inspector(s)
Britney Bartley (732787)
Ann McGregor (000704)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11-14, 18-21, 2023

The following intake(s) were inspected:

- Intake: #00087366 [Critical Incident (CI): 2693-000023-23] - Related to allegations of neglect of a resident
- Intakes: #00089105 [CI: 2693-000026-23], #00091207 [CI: 2693-000030-23] - Related to improper care of a resident
- Intake: #00089237 [CI: 2693-000027-23] - Related to a fall of a resident resulting in injury

- Intakes: #00093595 [CI: 2693-000033-23], #00095179 [CI: 2693-000036-23], #00095693 [CI: 2693-000037-23] – Were related to resident to resident abuse

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59 (b) identifying and implementing interventions.

The licensee has failed to ensure steps were taken to minimize the risk of harmful interactions between resident #003 and co-residents.

Rational and Summary:

i) Resident #003 has responsive behaviours. As per the resident's plan of care, staff were to monitor the resident to decrease negative interactions with co-residents.

Two staff heard resident #006 yelling and responded to the resident. Resident #006 was observed with injury and stated it was caused by resident #003. Resident #006 sustained injuries and the resident was sent to the hospital.

A staff who was assigned to care for resident #003 indicated the resident had a history of responsive behaviours. The home confirmed the staff were not following resident #003's plan of care by not providing planned interventions to prevent altercations with co-residents.

Failure to implement interventions related to resident #003's responsive behaviours led to the resident's altercations with other residents that resulted in injury of resident #006.

Sources: Residents' clinical records, interviews with the home's staff and management.

[732787]

Rational and Summary:

ii) Resident #003 has responsive behaviours. As per the resident's plan of care, staff were to monitor the resident to decrease negative interactions with co-residents.

Staff indicated they had witnessed resident #005 approach resident #003. An altercation occurred between resident #003 and resident #005. Staff indicated

resident #005 has a history of behaviours. Staff confirmed there were no staff monitoring resident #003 when the altercation occurred. Resident #005 was assessed by staff and as a result of the altercation resident #005 sustained an injury.

A staff indicated when the altercation occurred, they did not witness the altercation due to the view being obscured.

The home confirmed the staff were not following resident #003's plan of care to prevent altercations with co-residents.

Failure of the home to follow resident #003's responsive behaviour interventions led to a resident-resident altercation that resulted in resident #005 sustaining an injury.

Sources: Residents' clinical records, interviews with the home's staff and management

[732787]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee has failed to ensure that a person, who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary:
A resident sustained an injury while being transferred by staff. The staff was not familiar with the resident and did not know the correct equipment use for the resident.

The Director was notified a day after the incident occurred.

The DOC stated that the Director should have been notified immediately as the improper transfer resulted in a risk of harm to the resident.

Sources: Critical Incident (CI) report, interview with the home's management.

[000704]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse that resulted in harm of resident #004 had occurred, immediately report the information upon which it was based to the Director.

Rationale and Summary

Resident #004 attempted to take resident #003's personal assistive device and an altercation occurred between resident #003 and resident #004. On assessment, resident #004's sustained an injury.

The Critical Incident (CI) report was submitted to the Director and confirmed the altercation occurred the day before. The CI report also indicated the Director was not notified through an after hours call to the Ministry.

The home acknowledged the resident-to-resident altercation resulted in harm to resident #004 and it was to be immediately reported to the Director.

The home's failure to immediately report the resident-to-resident altercation, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Residents' clinical records, review of CI report, interviews with the home.

[732787]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Rationale and Summary

A resident sustained an injury while staff were assisting the resident with transferring.

Staff confirmed that they used the incorrect equipment to transfer the resident that resulted in the resident sustaining an injury. Staff were disciplined as a result of the incident.

The home confirmed that the staff did not follow the resident's plan of care and did not follow safe transferring and positioning techniques when transferring the resident and resulted in injury.

There was harm to the resident when staff did not use safe transferring and positioning techniques by not following the correct equipment for the resident as indicated in their care plan.

Sources: CI report, resident's care records, the home's policy, the home's investigation notes, interview with the home's staff and management

[000704]

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee failed to ensure that staff administering an intervention to a resident were performing the technique safely to maximize its effectiveness.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the policy for the intervention, including their orders, care plan, administration, and maintenance are complied with.

Specifically, staff did not label the intervention, did not disconnect the device from the resident when the device was not in use and allowed the medical device to remain in an open system for an extended period of time which was not in accordance with the home's policy.

Rationale and Summary
A resident was observed seated in an assistive device and they were connected to a medical device that was not in use and unlabeled.

Interview with a staff confirmed that the medical device was off because the specified time for the intervention had ended some time prior, that the system was open to the resident and that this was the usual practice. The staff confirmed there should have been a label applied to the intervention at the time of preparation.

Staff stated that the medical device was usually connected to the resident until it was time for the resident to be transferred from their personal assistive device to another location.

DOC #100 confirmed that the resident was not administered the intervention according to the home's policy.

There was risk to the resident for changes to their health status and complications when the intervention was not administered in accordance with the home's policy.

Sources: Inspector observations, home's policy, interview with the home's staff and management

[000704]

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary

Staff had missed that a medication had been discontinued for the resident. Staff continued to administer the medication to the resident. The resident was sent out to the hospital. The home confirmed that the resident had been administered a medication that was not prescribed. Staff did not follow best practices as outlined by the College of Nurses of Ontario (CNO) and the home's policies and procedures.

A resident was administered a medication they were not prescribed and as a result, was at risk for changes to their health status requiring transfer to the hospital.

Sources: The home's investigation notes, resident's clinical records, interviews with the home's staff and management, home's policies

[000708]