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

Public Report

Report Issue Date: January 17, 2025
Inspection Number: 2025-1193-0001
Inspection Type: Proactive Compliance Inspection
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6-10, 13-17, 2025.
The following intake(s) were inspected:

- Intake: #00134329 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure that the care set out for managing a resident's skin impairment was provided according to their care plan. Record reviews indicated that the resident needed a device due to a skin injury. However, during an observation, the device was not applied as per their care plan. The Registered Practical Nurse (RPN) noticed this error and immediately corrected it. The following day, the resident was observed receiving care in accordance with their care plan.

Sources: observations and the resident's health records.

Date Remedy Implemented: January 9, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the care plan for a resident was updated when there was a change in their pain medication. A review of the resident's written care plan showed discrepancies between the interventions listed in the care plan and the physician's orders for pain medications. The Director of Care (DOC) stated that registered staff should not include medication names in the care plan but should instead refer to the resident's electronic Medication Administration Record (eMAR). The resident's plan of care was updated the next day.

Sources: resident's plan of care and e-MAR, and interview with the DOC.

Date Remedy Implemented: January 9, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure all doors leading to non-residential areas are kept closed and locked in a Resident Home Area (RHA).

During the initial tour of the long-term care home, the inspector observed that two doors leading to non-residential areas were unlocked. These doors were not supervised by staff. RPN confirmed that these doors were unlocked and should be kept locked.

The Door audit record and the interview with the Environmental Service Team Lead confirmed that the lock for the specific door was replaced within a few hours. Furthermore, during the second observation, the inspection observed both doors were locked could not open it again without a key.

Sources: Observation, Interview with RPN and Environmental Service Team Lead, and Door Audit

Date Remedy Implemented: January 8, 2025.

WRITTEN NOTIFICATION: Personal Items and Personal Aids

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that the resident's personal items were labeled.

On an observation in an RHA in a shared bathroom room resident's personal items were kept unlabelled. In an interview, the IPAC Specialist confirmed all personal items are to be individualized and labeled for each resident.

Sources: Observation, interviews with IPAC specialist.

WRITTEN NOTIFICATION: Personal Items and Personal Aids

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (b)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(b) cleaned as required.

The licensee failed to ensure that the resident's personal items were cleaned and stored properly.
The inspector observed in an RHA in a shared bathroom room resident's personal items were not properly cleaned and stored. A record review of the home policy indicated that the resident's items must be cleaned regularly to maintain hygiene standards.

Sources: Observation, Southbridge Health Care LP-Standard Operating Procedure-Resident Personal Items-Cleaning and Labeling requirements procedure.

WRITTEN NOTIFICATION: Pain Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:

4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to comply with the home's pain management program when the registered nursing staff failed to assess the effectiveness of the pain medication for a resident. During the inspection, a resident expressed pain before their medication pass. The registered staff did not assess the resident's pain within an hour after administering the pain medication, nor did they assess the pain before giving their next pain medication dose.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies developed for the pain management program were complied with.

Specifically, the home's policy directed the staff to assess the effectiveness of pain control strategies pre- and post-intervention and determine if the effect of the intervention met the resident's goal for pain management or if pain intervention

requires adjustment within one hour of administration, which did not occur for the resident.

Sources: observations, home's pain management program, and interview with the quality manager (pain lead).