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: July 29, 2024

Inspection Number: 2024-1193-0002

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-12, 15-18, 2024

The following intake(s) were inspected:
Two Intakes: related to resident care and maintenance.
One intake: related to an allegation of resident to resident abuse.
One intake: related to pest control.
One intake: related to hospitalization of a resident.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care conference

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (b)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and

The licensee has failed to ensure that resident #007 was given an opportunity to participate fully in the care conference of the interdisciplinary team.

Rationale and Summary

A critical incident (CI) was submitted to the Director related to resident #007.

An annual interdisciplinary care conference was scheduled to discuss the resident's plan of care. The resident indicated they were not made aware of the conference nor invited to attend.

The Director of Care (DOC) indicated it is the expectation that a resident should be informed of their annual interdisciplinary care conference and of their right to attend. The DOC confirmed with the SSW that resident #007 was not invited to their annual

interdisciplinary care conference and was not advised of their right to attend.

Failure to ensure that resident #007 was invited to their care conference undermines their opportunity to fully participate in their care planning.

Sources: CI, resident #007's clinical record, interviews with DOC, resident #007, SSW.

WRITTEN NOTIFICATION: Social work and social services work

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 68
Social work and social services work
s. 68. Every licensee of a long-term care home shall ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs.

The licensee has failed to provide a written description of the social work and social services work provided in the home and evidence that the work meets the resident's needs.

Rationale and Summary

A CIR was submitted to the Director related to resident #007.

A review of the resident's clinical health record indicated the resident had stated that they would like to speak with someone. The SSW was made aware. No record was found to support the the SSW spoke with the resident after their request.

The SSW indicated that providing counselling to residents was part of their role. They indicated they check in with and say 'hi' to resident #007 frequently but that they have never provided the resident with counselling.

Admission and annual care conferences documentation were reviewed. There was no documentation in the area designated for social work in the admission or in the annual care conference.

The licensee was unable to provide a written description of the social work and social services provided in the home. A 'Position Description for Social Work / Resident Services Coordinator' (job description) was provided.

The DOC indicated the expectation is that interactions / conversations between residents and the SSW are to be documented in the resident's progress notes.

By failing to ensure there was a written description of social work and social services work in the home the licensee failed to identify and meet the psychosocial needs of the resident.

Sources: CI, resident #007's clinical record, LTC home's Position Description for Social Work / Resident Services Coordinator, interviews with DOC, BSO lead, SSW.

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