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: July 23, 2025

Inspection Number: 2025-1193-0004

Inspection Type:
Complaint
Critical Incident
Follow up

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): June 3- 6, 9-11, 13, 17- 20, 23-26, July 3, and 4, 2025

The inspection occurred offsite on the following date(s): June 30, 2025 and July 2, 2025

The following intake(s) were inspected:

- Intake related to Follow-up #: 1 - CO #001 / 2025-1193-0002, O. Reg. 246/22 - s. 78 (3) (b) Food Production, CDD May 31, 2025.
- Intake related to Follow-up #: 1 - O. Reg. 246/22 - s. 102 (9) (b); CDD: Jun.2, 2025.
- Intake related to a respiratory outbreak.
- Intake related to a complaint regarding care concerns
- Intake related to an incident that resulted injury, leading to a significant change

in their health status.
- Intake related to a complaint regarding the temperature in the home.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1193-0002 related to O. Reg. 246/22, s. 78 (3) (b)
Order #002 from Inspection #2025-1193-0002 related to O. Reg. 246/22, s. 102 (9) (b)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

An observation was conducted outside the home in the designated smoking area, where a bench commonly used by residents was found to have a missing wooden panel on the seating surface. This bench was observed to have exposed rusted metal and protruding nails on each side.

Sources: Observations.

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 an allegation of improper care that resulted in risk of harm to a resident was reported to the Director.

A resident made an allegation that staff had been rough during care resulting in the resident experiencing pain. The home's complaint records indicated the concern was not reported to the Director. The Registered Nurse (RN) and the Director of Care (DOC) confirmed that the allegation should have been reported to the Director.

Sources: The home's complaint records, interviews with the RN and the DOC.

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee has failed to ensure that doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

During observations of a resident home area (RHA), the inspector noted that the balcony door in the dining room was unlocked, with a sign attached stating "use at your own risk".

Sources: Observations.

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is

equipped with a resident-staff communication and response system that,
(b) is on at all times;

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

On a tour of the home, it was observed that the communication and response system inside three resident rooms not functioning when activated.

Sources: Observations of resident rooms.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's plan of care related to continence care and management was implemented.

A complaint was submitted to the Ministry of Long Term Care (MLTC) related to multiple concerns including inadequate continence care. The complainant alleged that a resident's continence care needs were not being met.

The resident's plan of care indicated the resident required a specific intervention in order to meet their continence needs. The resident and staff confirmed that the intervention was not in place.

Sources: The resident's plan of care, interviews with the resident and staff.

WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee has failed to ensure that common areas and staff areas, including wall surfaces were cleaned.

During observations of the home, the inspector noted black dried stains on multiple areas of the home. According to the home's monthly cleaning routine, in addition to daily and weekly tasks, the staff were required to wipe down walls, vents, and baseboards.

Sources: Observations and the home's monthly cleaning routine.

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when a resident submitted a verbal complaint to the home, that a response was provided to the complainant.

A complaint was submitted to the MLTC related to multiple areas of care in regards to a resident including the lack of response to the resident's concerns.

A review of the home's complaints records indicated that the resident submitted a verbal complaint where harm was alleged. The records further indicated that no response was provided to the resident. The DOC confirmed that a response should have been provided to the resident.

Sources: the home's complaints records, interview with the DOC.

COMPLIANCE ORDER CO #001 Plan of care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. The DOC and or designate shall review the plan of care for the resident with all staff from all shifts involved in the provision of care related to the resident. The review shall focus on smoking needs and the level of support needed to ensure the resident's safety when they are smoking.

2. The DOC and or designate shall conduct weekly audits for four weeks to ensure the interventions in the written care plan are completed as directed in the plan of care.

3. The DOC and or designate shall keep a record of the plan of care review and the audits completed, including any corrective actions taken.

Grounds

The licensee has failed to ensure that the care set out in the plan of care for a resident, related to smoking was provided as specified in the plan.

During the inspection a resident was observed in the smoking area with two other residents, who were all smoking, the resident was observed with a device at the time of the observation.

As per the resident's plan of care, staff are to monitor the device when smoking and remind resident to move the device to a safe area while resident is smoking.

The device's close proximity to the resident posed a significant fire hazard, creating a risk of serious harm to resident and the two other residents present.

Sources: Observations, review of the resident's written care plan and interview with the Director of Care.

This order must be complied with by August 29, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the past 36 months, a CO(HP) under FLTCA, 2021, s. 6 (7) was issued #2025-1193-0003 on April 8, 2025.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall

1) Conduct audits twice weekly for two weeks of the resident's call bell with the purpose of ensuring that the call bell remains within reach and can be used by the resident.
2) Keep a record of the date and time of audit, staff performing the audit, result and actions taken if needed as a result of the audit.
3) The home shall conduct an interview once weekly with the resident for three weeks to assess the resident's satisfaction with the timeliness of the staff's response when the resident uses the call bell. The home is to document the resident's responses and actions taken if needed.
4) Keep a record of the date and time of the interview, staff performing the interview, result and actions taken if needed as a result of the interview.
5) Provide the resident a call bell that meets the resident's needs in the resident's bathroom.

Grounds

The licensee has failed to ensure that a resident were not neglected by the licensee or staff.

Section 7 of the O. Reg 246/22 defines neglect as 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 complaint was submitted to the MLTC related to multiple areas of concern with a resident's care including lack of access to a call bell. A review of the resident's records show that the resident required assistance from staff to perform activities of daily living.

The progress notes show the resident's health deteriorated and became unable to use the home's standard call bell. A request to provide a call bell to the resident that met their needs was received by staff until 41 days later. Additionally, during the inspector's observations, the call bell in the resident's bathroom was noted to be a call bell the resident was unable to use. The resident informed the inspector that due to their medical condition, they were unable to use the call bell by the bedside for 41 days, and that a call bell that met their needs was never provided in the resident's bathroom.

The DOC stated that when a resident is no longer able to use the regular call bell, an assessment is done to determine the appropriate type of call bell, and frequent checks are done on the resident until the resident receives the appropriate call bell. The DOC notified the inspector that they were not made aware of the resident's request until days before the call bell was installed, and also confirmed that the home was required to provide this service to the resident. The resident confirmed that for 41 days the absence of a usable call bell resulted in delays in receiving care and her inability to voice their needs.

Given the resident's high level of dependence, the absence of an accessible call bell for 41 days posed a significant risk, affecting the resident's dignity, autonomy, and physical well-being.

Sources: Progress notes, care plan, observations, interview with the resident, and the DOC.

This order must be complied with by August 29, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the past 36 months, a CO under FLTCA, 2021, s. 24 (1) was issued under report #2023-1193-0004 on June 28, 2023

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the

licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Plan of care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) The DOC or designate will provide training to all staff responsible for completing a safe smoking assessment on the home's policy for Safe Smoking/Vaping.
2) Keep a documented record of who delivered the training, names of staff who attended the training, date and time of the training.
3) The DOC or designate will audit all resident's who smoke at the home to ensure that there smoking safety decision and plan of care are revised, up to date and implemented by the home.
4) Keep a documented record of who conducted the audit, the date the audit was completed, names of residents and corrective action taken.

Grounds

The licensee has failed to ensure that a resident's plan of care was based on an

interdisciplinary assessment of the safety risks with respect to the resident.

A Critical Incident Report (CIR) was submitted to the Director following an incident that resulted in serious injury and a significant change in a resident's health status.

On a specified date, an incident occurred in the smoking area where a resident's clothes caught fire resulting in significant injuries that resulted in the resident being transferred to another medical facility.

Review of the resident's safety smoking assessment completed indicated that when the registered staff conducted the assessment they identified concerns in the assessment. The assessment concluded the resident could smoke independently.

Interview with DOC confirmed that upon the completion of the assessment in conjunction with the resident's cognition status, and previous incidents related to smoking concerns, the resident's smoking safety decision should have been changed to a supervised status.

Not revising the resident's plan of care prevented the home from identifying and mitigating potential risks related to smoking unsupervised.

Sources: The resident's clinical records and interviews with DOC.

This order must be complied with by August 29, 2025

COMPLIANCE ORDER CO #004 Cooling requirements

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (4) (b)

Cooling requirements
s. 23 (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2), (3) and (4) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 246/22, s. 23 (4).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) The Executive Director (ED) will conduct a root cause analysis (RCA) focused on the response to the air conditioning malfunction that occurred on June 4, 2025. The findings of the RCA and the actions taken must be documented.

This RCA must:

- Identify all gaps and deficiencies in the home's response to the malfunction
- Outline corrective actions taken to address the identified gaps
- Include recommendations and preventative strategies to ensure improved response in future incidents

2) The ED will select two interviewable residents that reside on the specified RHAs. The residents will be interviewed once a week for three weeks with the purpose of verifying that the temperature in their rooms is kept at a comfortable temperature.

3) Keep a documented record of who completed the interviews, date and time of the interviews, name of residents interviewed, any concerns brought up related to the temperature of the rooms, and any action taken if necessary.

4) The licensee will designate a person to educate the leadership team on the home's heat illness prevention and management plan, ensuring they understand their departmental roles and responsibilities, including when to initiate the plan and its key components.

5) Keep a documented record of the material reviewed, the date, name and tittle of who delivered the training and the date, name and tittle of who attended the training.

Grounds

The licensee has failed to ensure that the heat related illness prevention and management plan for the home was implemented when the temperature in areas in

the home, measured by the licensee, reached 26 degrees Celsius or above on identified dates.

Rationale and Summary

During an on-site inspection on four consecutive days, it was observed that the temperatures in the home were elevated. Staff and residents were observed perspiring and multiple staff and residents voiced concerns related to the safety of the residents as a result of the temperature in the home. Upon inquiring about the home's temperature, the inspector was informed that the home's central air conditioning system which serviced the front entrance, and two resident home areas had malfunctioned. The inspector noted that

two home areas affecting 62 resident rooms

were affected by the malfunction.

The home's Air Temperature Monitoring Policy, states that in the event the indoor temperature measured in any area of the home reads 26 degrees or above, the home is required to implement the heat related illness prevention and management plan.

Observations conducted, and staff interviews confirmed that the home had not implemented the Cooling/Heat-related Illness Prevention and Management Plan for residents for three days, specific to Hydration Protocols during hot weather and Physical Maintenance. This placed the residents on Aspen and Cedar at increased risk of heat related illness.

Sources:

Home's Heat related illness prevention and management plan and interviews.

This order must be complied with by

August 29, 2025

COMPLIANCE ORDER CO #005 Air temperature

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 24 (4) (a)

Air temperature

s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,

(a) every day during the period of May 15 to September 15; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Educate the management team on the specified policies

2) Train those responsible for taking temperatures and the ED on the home's process for temperature checks required when the air conditioning is not operational.

3) Keep a documented record of the material reviewed, the date, name and tittle of who delivered the training and the date, name and tittle of who attended the training.

Grounds

The Licensee has failed to ensure that, for every resident bedroom in which air conditioning is not operational, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. every day during the period of May 15 to September 15.

Rationale and Summary

During a tour of two resident home areas, it was verified that the air conditioning system malfunction was directly affecting the units.

Air temperature documentation was requested from the home in response to warm temperature concerns, including a malfunctioned air conditioning system, which directly affected the front entrance, and two RHAs.

The inspector requested temperature logs for the affected RHAs for specified dates. The Executive Director (ED) confirmed that the temperature logs were completed by a staff who had left for the day. The staff confirmed in an interview, that they had

not completed the requested temperature logs during the specified time frame and was not aware that this was required.

The ED provided the inspector with the requested temperature logs, each bearing two different staff signatures. During a review of the home's surveillance footage for the dates and times documented on the forms provided by the ED, no staff were observed measuring the temperature in the resident rooms affected by the malfunction of the air conditioning system with no portable air conditioning units.

The staff members whose names appeared on the logs later clarified that they had not completed the temperature readings as recorded. They further indicated that they were asked to fill in the logs retrospectively for dates and times when temperature readings had not been taken.

Failure to measure and document the temperature in 62 resident rooms without a working air conditioning unit prevented the home from potentially identifying and mitigating heat related illnesses in residents. During this period, residents reported significant distress and discomfort due to the elevated temperatures.

Sources:

Temperature logs, surveillance footage, interviews with the Executive Director and staff.

This order must be complied with by

August 29, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

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
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: 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.