Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2016	2016_327570_0022	028986-16	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 04-07, 2016 and October 11, 2016

Compliant inspection Log #028986-16 related to an allegation of abuse.

The following were inspected during the course of this Complaint Inspection:
Critical Incident Logs:
Intake Log #028873-16: Related to an allegation of abuse.
Intake Log #028980-16: Related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, the licensee`s Regional Director, Director of Care (DOC), Residents, Registered Nurse (RN), Resident Care Area Manager (RCAM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), MDS-RAI Coordinator and Family member.

During the course of this inspection, the inspector toured the home, observed staff to resident interactions and provision of care; reviewed clinical health records of identified resident, the licensee's investigation notes and relevant policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Related to Log #028986-16

On a specified date, the Ministry of Health and Long-Term Care received a concern related to resident #001. The resident was using a tilt wheelchair and the resident was supposed to be in the tilt position when sitting in wheelchair. On several occasions when visiting, the resident was not observed in the tilt position while seated in the wheelchair and the resident was at risk for falls.

Inspector #570 reviewed the clinical records for resident #001, which indicated the resident was admitted to the home on a specified date with multiple diagnoses including cognitive decline. The resident was identified as a high risk for falls related to poor balance secondary to specified medical conditions and tendency to get up from bed or wheelchair.

On October 05, 2016 at 1035 hours the inspector observed resident #001 sitting in wheelchair (not tilted) against the wall in the hallway across from nursing station of an identified unit until taken to lunch. The resident was observed by the inspector to be sleeping and was not checked upon by staff during the observation period.

On October 06, 2016 at 1015 hours, resident #001 was observed by the inspector sitting in wheelchair (not tilted) in the hallway across from nursing station of an identified unit from 0930 hours; the resident was awake and calm.

The current plan of care for resident #001 reviewed by the inspector on October 6, 2016 indicated under Personal Assistance Service Devices (PASDs): Family requested to have wheelchair tilted when resident is seated in the chair; PSW to ensure wheelchair was tilted when the resident is up in wheelchair to ensure that the resident is positioned properly and comfortable.

During interviews with inspector #570 on October 6 and 11, 2016 with PSWs #110, 115 and 116, it was indicated that resident #001's wheelchair was not tilted all the time when the resident was sitting in the wheelchair; the wheelchair was to be tilted when the resident was sleeping and restless or trying to get up.

On October 11, 2016 at 1000 hours, the inspector observed resident #001 sleeping while sitting in the wheelchair (not tilted) in front of the nursing station. RPN #122 indicated to the inspector that the resident was supposed to be tilted as per care plan on Point Click Care (PCC) electronic documentation system; and because the resident was sleeping,

the wheelchair should have been tilted.

The care set out in the plan of care related to tilting the wheelchair when used by resident #001 was not provided as specified in the current plan of care.

A compliance order was issued under inspection # 2016_327570_0014 related to s. 6. Plan of care, with a compliance date of October 31, 2016. Therefore this noncompliance is issued as a written notification (WN). [s. 6. (7)]

Issued on this 7th day of December, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.