Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8iém étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002

Télécopieur: 416-327-4486

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 28, 2011	2011_132_1101_25 May173027	C/O-T938

Licensee/Titulaire
Jarlette Ltd.
689 Yonge Street
Midland, ON L4R 2E1
(705) 526-4238
Fax: (705) 526-5080

Long-Term Care Home/Foyer de soins de longue durée
The Villa Care Centre
689 Yonge Street
Midland, ON L4R 2E1
(705) 526-4238
Fax: (705) 526-5080

Name of Inspector(s)/Nom de l'inspecteur(s)
Rosemary Lam (#132)- Nursing

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to resident injury.

During the course of the inspection, the inspector(s) spoke with: Registered nursing staff, personal support workers and members of the management team, including Director and Assistant Director of Care.

During the course of the inspection, the inspector(s): Reviewed resident health records, inspected various common areas and observed staff providing care to residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, 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.

Findings:

- An identified resident did not receive denture care as set out in the plan of care for denture care.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring staff provides care as specified in the plan of care. This plan of correction is to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6(9) 1. The licensee shall ensure that the following are documented: 1. The provision of the care set out in the plan of care.

Findings:

- **Denture care provided was not documented as required by the resident's plan of care.**

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring staff documents care provided as set out in the plan of care. This plan of correction is to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007,c.8, s. 5 Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:

The 3rd floor hallway does not allow for safe resident passage as equipment was stored on both sides of the hallway:

- **On April 28, 2011 at 0830am – inspector observed in hallway behind the 3rd floor servery that a dietary cart intended for soiled dishes was positioned at the right side of hallway, while 3 residents lifts were seen lined up on the left side of hallway, directly opposite to the dietary cart. Space available in the middle was very narrow, making it difficult for residents to safely or easily pass. Dietary staff interviewed indicated resident lifts have taken up space normally**

used for parking the dietary cart.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure equipment is stored safely and allowing residents and staff to pass safely in the hallway. This plan of correction is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. **Rosemary Lam**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 24, 2011