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 of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 27, 28, 29, 2011, May 5, 2011	2011_195_1101_10May095634	Critical Incident Log # T480

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 Inspectors/Nom de l'inspecteurs

Tiziana Picardo – 195

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Director of Resident Care, Registered Staff

During the course of the inspection, the inspector observed residents, interviewed staff, reviewed the health record, and reviewed policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:
Responsive Behaviours
Critical Incident Response

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

[2] WN
[1] 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.	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-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.)	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, c. 8, s. 6 (1)(c). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

The licensee has failed to ensure that an identified resident's written plan of care provides clear directions to staff and others who provide direct care to the identified resident.

- An identified resident's care plan related to verbal and physical aggression has not been revised to address the identified resident's aggression towards residents.
- Progress notes indicate that the identified resident was physically aggressive towards residents.

Inspector ID #:	195

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 ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. The plan is to be implemented voluntarily.

WN #2 - The Licensee has failed to comply with **LTCHA, 2007 c. 8, s. 24(2). 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:**

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

The licensee failed to ensure that critical incident was immediately reported to the director. The incident was reported the day after the occurrence via the online Critical Incident System to the Ministry of Health and Long-Term Care.

Inspector ID #:	195

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. Tiziana Picardo
Title: Date:	Date of Report: June 6, 2011