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 prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 07, 2019	2018_657681_0028 (A1)	003543-17, 007490-17, 007827-17, 027746-17, 003697-18, 010710-18, 012763-18, 013877-18, 014194-18, 017623-18, 022380-18, 023860-18, 025940-18, 028706-18, 030384-18, 030756-18	Critical Incident System

Licensee/Titulaire de permis

Jarlette Ltd.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

The Villa Care Centre
689 Yonge Street MIDLAND ON L4R 2E1

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

Amended by TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #001 rescinded.

Issued on this 7 th day of February, 2019 (A1)

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

Original report signed by the inspector.

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

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

Amended by TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 26 - 30, 2018, and December 3 - 7, 2018.

The following intakes were inspected on during this Critical Incident System inspection:

- Four intakes related to allegations of staff to resident abuse or neglect.

- Four intakes related to allegations of resident to resident abuse.

- One intake related to a safety incident that occurred.

- Four intakes related to falls that resulted in injury to residents.

- Three intakes related to missing or unaccounted for controlled substances.

A Follow up inspection #2018_657681_0026 and a Complaint inspection

#2018_657681_0027 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Director of Care (Co-DOC), Staff Educators, Nutrition Manager, Resident and Family Services Coordinator, Restorative Care Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Laundry staff, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.

6 WN(s)
2 VPC(s)
2 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	Légende 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. 71. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home had a Director of Nursing and Personal Care.

Inspector #681 reviewed the home's list of staff members and identified that there was not a Director of Care (DOC) in the home.

During an interview with the Administrator on November 28, 2018, they stated that DOC #102's last day of work was November 13, 2018. The Administrator stated that the DOC workload was being shared amongst existing team members. The Administrator stated that the Co-DOC was familiar with the DOC role and that they would typically take over the DOC role when the DOC was on vacation or off sick.

During an interview with the Co-DOC, they stated that they were responsible for assisting the DOC with overseeing and managing the nursing department.

In a subsequent interview with the Administrator on December 7, 2018, they indicated that the home had still not filled the DOC position, nor had anyone moved into the position of Acting DOC. [s. 71. (1)]

Additional Required Actions:

(A1)
The following order(s) have been rescinded: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home protected residents from abuse by anyone and ensured that residents were not neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted to the Director related to an incident that occurred, where PSW #127 improperly transferred resident #021.

A) Inspector #638 reviewed the CIS report and identified that resident #021 reported that PSW #127 improperly transferred them, which resulted in injury. The report indicated that the resident tried to tell the PSW about their transfer requirements, but that the PSW would not listen.

The Inspector reviewed PSW #128’s written account of the incident. PSW #128 was working on the date of the incident and had been assisting with resident #021's care. PSW #128’s written account identified that resident #021 was upset following the transfer. The next day, resident #021 told PSW #128 that they were experiencing pain from the improper transfer.

Please refer to WN #4, Finding #1 for further details.

B) Inspector #638 reviewed the CIS report and identified that the CIS report was initiated on a specified date, two days after the incident occurred.

Section 24, subsection 1 of the Long-Term Care Homes Act (LTCHA) 2007, stipulates that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, shall immediately report the suspicion and the information upon which it is based to the Director.

Please refer to WN #6 for further details.

C) The Inspector reviewed the home’s internal investigation notes and identified

that PSW #127 worked a shift on a specified date, while the outcome of investigation related to the improper care of resident #021 was still pending. The notes identified that the PSW was called in by staff because their shift had not been removed from the schedule. The PSW stated that they did not tell staff that they were not supposed to be in the building.

During an interview with Inspector #638, RN #113 indicated that when a staff member was put off pending investigation, they would be identified as a "Leave of Absence (LOA)" on the call in list so that they would not be accidentally called in during their leave.
The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, indicated that the resident would be protected from having any further interactions or communications with the alleged abuser until an investigation had been completed, and thereafter, if abuse or neglect were found to have occurred.

In an interview with Inspector #638, the Administrator and Co-DOC indicated that there were many different schedules in the home and that PSW #127's scheduled shift had not been crossed off pending the completion of the investigation. The Administrator and Co-DOC identified that PSW #127 worked a full shift on a specified date, when they were supposed to be off pending investigation for improper and neglectful care.

The Inspector reviewed the entire series of events with the Administrator and Co-DOC and identified the following:

-the incident of improper care that occurred and resulted in injury to the resident;
-PSW #127 finished their shift after the incident occurred.
-the Co-DOC was advised of the incident on the date that it occurred, but an investigation was not initiated until two days later;
-PSW #127 came in for a shift on a specified date, while they were supposed to be off pending the outcome of the home's investigation; and
-the incident was not reported to the Director until two days after the incident had occurred.

Upon reviewing the series of events, the Inspector inquired if the Administrator and Co-DOC believed that the home's actions protected residents from the potentially neglectful care of PSW #127. The Administrator and Co-DOC acknowledged that the home failed to protect residents from neglect. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A) A CIS report was submitted to the Director which indicated that resident #010 exhibited a specified responsive behaviour towards resident #011.

Inspector #543 reviewed resident #010’s health care record, which indicated that this resident had a specified intervention initiated on a particular date.

Inspector #543 reviewed the documentation related to the specified intervention for a particular one week time period. The Inspector identified that the scheduled intervention lacked documentation on all seven of the dates reviewed by the Inspector.

B) A CIS report was submitted to the Director, which indicated that resident #016 exhibited a specified responsive behaviour towards resident #008’s that resulted

in resident #008 being injured.

Inspector #543 reviewed resident #016’s health care record and identified that a specified intervention had been initiated.

The Inspector reviewed the documentation related to the specified intervention for a particular one week time period. The Inspector identified that the scheduled intervention lacked documentation on all seven of the dates reviewed by the Inspector.

The Inspector reviewed the home's "Resident Rights, Care and Services-Responsive-Program" policy, last revised August 21, 2017. The policy indicated that staff would participate in, and complete documentation that was required for any assessment of the resident.

The Inspector interviewed PSW #129 and #131, who stated that residents who required a specified intervention should have that intervention implemented and that the documentation related to that intervention should be completed as required.

The Inspector interviewed RN #113, who indicated that the documentation associated with the specified intervention was to be completed for the entire time period the intervention was ordered.

The Inspector interviewed the Co-DOC, who stated that it was the expectation that each shift complete the required documentation for as long as the specified intervention was ordered for a resident.

The Inspector interviewed the Administrator who verified that every staff member who was working on the unit was responsible for documenting and that it was the expectation that the documentation for the specified intervention was completed.

The Co-DOC and the Administrator acknowledged that the documentation was not completed in its entirety. [s. 6. (9) 2.]

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 that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Neglect is defined within the Ontario Regulation 79/10, 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 CIS report was submitted to the Director related to an incident that occurred, where PSW #127 improperly transferred resident #021. The CIS report indicated that the resident identified that PSW #127 improperly transferred them, which resulted in an injury. The report also identified that the resident tried to tell the PSW about their transfer requirements, but the PSW would not listen to the resident.

Inspector #638 reviewed resident #021's health care records and identified that the resident's care plan indicated a specified intervention for transferring resident #021.

The Inspector reviewed the home's internal investigation notes, which included documentation from an interview with PSW #127, which indicated that the PSW was aware that they were to follow the transfer requirements identified in the resident's plan of care. The interview identified that PSW #127 used the proper transfer interventions for resident #021 earlier in the shift, but then proceeded to improperly transfer the resident. PSW #127 acknowledged that they did not follow the home's policy, and that they had scared the resident.

Inspector #638 reviewed PSW #128's written account of the incident, which indicated that resident #021 was upset after the transfer occurred. The written account identified that the resident repeatedly told PSW #127 of their transfer requirements during the transfer. The following day the resident told PSW #128 that they were experiencing pain from the transfer.

In an interview with PSW #131, they stated that direct care staff were required to follow the interventions outlined in the resident's plan of care. PSW #131 stated that it would not be acceptable in any circumstance to not follow the transfer interventions outlined in the resident's plan of care. PSW #131 indicated that it could be considered neglectful of a resident's safety needs, if staff knowingly did not implement a resident's planned care. PSW #131 also identified that neglectful care could occur if staff were unsure of a resident's interventions and did not verify resident specific care interventions prior to providing the care.

During an interview with Inspector #638, RN #113 stated that staff were expected to refer to the resident's care plan or kardex for specific care interventions. The RN indicated that staff who were unsure of a resident's care interventions and did not review the care plan or knowingly ignored the planned care in the resident's plan, could be considered neglectful because it had the potential to put the resident's safety at risk. The RN stated that staff, who did not follow a resident's assessed transfer interventions, would be putting the resident at risk of injury.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, defined 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. The policy further indicated that residents would be treated with dignity and respect and would live free from abuse and neglect.

In an interview with Inspector #638, the Administrator and Co-DOC stated that PSW #127 was aware of where to access resident specific care information and was trained on the safe transferring of residents. The Administrator and Co-DOC indicated that, during the investigation, PSW #127 did not see anything wrong with their actions and did not understand the safety concerns related to the incident. Upon reviewing the definition of neglect with the Administrator and Co-DOC, they stated that PSW #127’s actions were considered neglectful towards resident #021. [s. 20. (1)]

2. A CIS report was submitted to the Director related to an allegation of staff to resident neglect. The CIS report indicated that on a particular date, resident #008 was found in an inappropriate condition.

a) Inspector #681 reviewed the home’s investigation notes related to the incident, which indicated that PSW #132 was assigned to resident #008 on a particular date. The investigation notes indicated that PSW #132 provided some care to resident #008, but that the resident was not provided with all their care because they had refused specific aspects of care. The investigation notes also indicated that when care was provided by PSW #111 and PSW #135, resident #008 was found in an inappropriate condition and was complaining of pain.

During an interview with PSW #111, they stated that on a particular date, they found resident #008 in an inappropriate condition. PSW #111 stated that resident #008 was known to refuse care, but staff could usually provide the required care with some encouragement.

Inspector #681 reviewed a letter of discipline addressed to PSW #132, which indicated that PSW #132 received disciplinary action for their unacceptable actions around neglecting a resident on a specified date. The letter indicated that personal care was not provided to a resident despite PSW #132 noticing that the resident required specified care.

During an interview with the Co-DOC, they stated that PSW #132 was disciplined for not providing the required care to resident #008.

b) Inspector #681 reviewed the home’s investigation notes related to the incident, which indicated that PSW #111 and PSW #135 reported concerns about resident #008 having not received necessary care to RN #133 on a specified date and time. The investigation notes further indicated that RN #133 left a voicemail

message about the incident on DOC #102's answering machine on the date that they became aware of the allegation.

During an interview with RN #133, they stated that they were unable to recall the incident involving resident #008. RN #133 stated that suspicions or allegations of resident abuse or neglect would be reported to them and then they would report this to management, or the manager on-call, if it was outside of normal business hours.

The home's policy titled "Resident Rights, Care And Services - Abuse - Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, identified that any person who had reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the Charge Nurse, if no manager was on site at the Home. The Charge Nurse was to promptly notify the Administrator and/or Director of Care of the alleged, suspected, or witnessed incident of abuse or neglect. The Administrator or Director of Care was to then immediately notify the Ministry of Health and Long Term Care via the after hours pager, if it was outside of normal business hours, and complete a Critical Incident System Report during normal business hours.

During an interview with the Co-DOC, they stated that the management of the home became aware of the incident because a voicemail message was left for DOC #102 on their answering machine at the home. The Co-DOC stated that the incident should have been immediately brought to the attention of the manager on-call so that the Director could have been notified about the incident through the after-hours pager. [s. 20. (1)]

3. A CIS report was submitted to the Director related to an allegation of staff to resident neglect. The CIS report indicated that resident #009 was left in an inappropriate condition with their privacy curtain open on a specified date. As a result of the incident, resident #009 sustained an injury.

Inspector #681 reviewed the home's investigation notes related to the incident, which indicated that RPN #136 found resident #009 in an inappropriate condition on a specified date and time. Resident #009's privacy curtain was open and the resident was visible to other residents in the home. The investigation notes further indicated that PSW #137 and PSW #138 acknowledged that they left resident #009 in an inappropriate condition two hours prior to the time when resident #009 was found by RPN #136. PSW #137 and PSW #138 also acknowledged that they

did not provide the resident with appropriate privacy.

During an interview with RPN #136, they stated that they found resident #009 in an inappropriate condition and that privacy had not been provided to the resident.

The Inspector reviewed two separate letters that were addressed to PSW #137 and #138, which indicated that PSW #137 and #138 received disciplinary action for leaving a resident in an inappropriate condition and not maintaining the privacy of the resident.

During an interview with the Co-DOC, they stated that the allegation of neglect was substantiated and the resident's privacy was not maintained. The Co-DOC stated that both PSW #137 and PSW #138 received disciplinary action related to the incident. [s. 20. (1)]

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 that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 136 (1), the licensee was required to ensure that, as part of the medication management system, a written policy was developed in the home that provided for the ongoing identification, destruction and disposal of,
(a) all expired drugs;
(b) all drugs with illegible labels;
(c) all drugs that were in containers that did not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
(d) a resident's drugs where, (i) the prescriber attending the resident orderd that the use of the drug be discontinued, (ii) the resident died, subject to obtaining the written approval of the person who had signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or (iii) the resident was discharged and the drugs prescribed for the resident were not sent with the resident under section 128.

Specifically, staff did not comply with the policy titled "Resident Rights, Care and Services – Medication Management – Drug Disposal and Wasting of Medications", last revised July 20, 2017, which is part of the licensee "Medication Management System" program.

A CIS report was submitted to the Director, related to missing or unaccounted for controlled substances. Inspector #638 reviewed the CIS report which identified

that RN #124 and RPN #125 were discontinuing a medication for resident #022. The CIS report identified that both registered staff members involved stated that they gave the medication to the other registered staff member to be disposed. However, at the time of destruction, it was identified that the medication for resident #022 was missing from the drug destruction bin.

Inspector #638 reviewed the internal investigation notes, which included documentation from an interview with RPN #125. The interview identified that RN #124 approached RPN #125 to confirm the discontinued medication and RN #124 took the medication to the drug destruction bin. Documentation from a interview with RN #124 identified that the RN alleged that RPN #125 had taken the medication to the drug destruction bin on their own. RN #124 indicated that the proper process was for both registered staff to put the discontinued medication into the drug destruction bin.

The Inspector also reviewed documentation from interviews that the home conducted on a specified date, where the home questioned registered staff about the process for the disposal of controlled substances. The interviews indicated that RPN #126 and RPN #112 also stated that they placed controlled substances into the bin without a second registered staff member present.

In an interview with Inspector #638, RPN #118 stated that the discontinuation of controlled substances required two registered staff members working together.

During an interview with Inspector #638, RN #119 indicated that discontinuation of controlled substances involved two registered staff counting the medication and placing them in the drug destruction bin.

The home's policy titled "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications" identified that when a controlled medication was removed from active supply, two registered staff were responsible for discarding the controlled medication in the discontinued controlled substances box.

The Inspector interviewed the Administrator, who stated that the home's process for discontinuing controlled substances involved two registered staff members acting together to discard the medications. The Inspector questioned whether registered staff had complied with the home's policy related to drug disposal on the specified date, and the Administrator stated that the staff members did not

follow the home's policy at the time. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director related to an incident where PSW #127 improperly transferred resident #021. Please refer to WN #4, Finding #1 for further details.

Inspector #638 reviewed the CIS report and identified that the report was initiated

on a particular date, two days after the incident occurred.

The Inspector interviewed PSW #131, who indicated that, if they suspected improper care or neglect towards a resident had occurred, they would immediately report the suspicion to the charge nurse. The PSW stated they could also report to the home’s management team if they were not comfortable approaching the charge nurse.

During an interview with Inspector #638, RN #113 indicated that any suspicion or reported incidents of improper care would be immediately investigated. The RN identified an incident report would be written and management would be notified of the incident. RN #113 stated that the manager on-call would be contacted if it was after business hours and that the charge nurse could notify the Director via the after-hours line.

The home’s policy titled “Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect” last revised June 2017, identified that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident should immediately report the suspicion and the information upon which it was based to the Ministry of Health and Long Term Care.

In an interview with Inspector #638, the Co-DOC indicated that they were made aware of the incident regarding PSW #127 on the date the incident occurred. The Co-DOC identified that they did not immediately report the incident because they were planning to look into the incident on the next business day. The Co-DOC stated that, upon following up on the incident, they identified improper (neglectful) care and stated they should have immediately reported the incident to the Director. [s. 24. (1)]

Issued on this 7 th day of February, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TIFFANY BOUCHER (543) - (A1)
Inspection No. / No de l'inspection :	2018_657681_0028 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003543-17, 007490-17, 007827-17, 027746-17, 003697-18, 010710-18, 012763-18, 013877-18, 014194-18, 017623-18, 022380-18, 023860-18, 025940-18, 028706-18, 030384-18, 030756-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 07, 2019(A1)
Licensee / Titulaire de permis :	Jarlette Ltd. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	The Villa Care Centre 689 Yonge Street, MIDLAND, ON, L4R-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jill Wismer

To Jarlette Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

Specifically, the licensee must ensure that all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the home protected residents from abuse by anyone and ensured that residents were not neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted to the Director related to an incident that occurred, where PSW #127 improperly transferred resident #021.

A) Inspector #638 reviewed the CIS report and identified that resident #021 reported that PSW #127 improperly transferred them, which resulted in injury. The report indicated that the resident tried to tell the PSW about their transfer requirements, but that the PSW would not listen.

The Inspector reviewed PSW #128's written account of the incident. PSW #128 was working on the date of the incident and had been assisting with resident #021's care. PSW #128's written account identified that resident #021 was upset following the transfer. The next day, resident #021 told PSW #128 that they were experiencing pain from the improper transfer.

Please refer to WN #4, Finding #1 of inspection report #2018_657681_0028 for

further details.

B) Inspector #638 reviewed the CIS report and identified that the CIS report was initiated on a specified date, two days after the incident occurred.

Section 24, subsection 1 of the Long-Term Care Homes Act (LTCHA) 2007, stipulates that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, shall immediately report the suspicion and the information upon which it is based to the Director.

Please refer to WN #6 of inspection report #2018_657681_0028 for further details.

C) The Inspector reviewed the home's internal investigation notes and identified that PSW #127 worked a shift on a specified date, while the outcome of investigation related to the improper care of resident #021 was still pending. The notes identified that the PSW was called in by staff because their shift had not been removed from the schedule. The PSW stated that they did not tell staff that they were not supposed to be in the building.

During an interview with Inspector #638, RN #113 indicated that when a staff member was put off pending investigation, they would be identified as a "Leave of Absence (LOA)" on the call in list so that they would not be accidentally called in during their leave.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2017, indicated that the resident would be protected from having any further interactions or communications with the alleged abuser until an investigation had been completed, and thereafter, if abuse or neglect were found to have occurred.

In an interview with Inspector #638, the Administrator and Co-DOC indicated that there were many different schedules in the home and that PSW #127's scheduled shift had not been crossed off pending the completion of the investigation. The Administrator and Co-DOC identified that PSW #127 worked a full shift on a specified date, when they were supposed to be off pending investigation for improper and neglectful care.

The Inspector reviewed the entire series of events with the Administrator and Co-DOC and identified the following:

-the incident of improper care that occurred and resulted in injury to the resident;
-PSW #127 finished their shift after the incident occurred.
-the Co-DOC was advised of the incident on the date that it occurred, but an investigation was not initiated until two days later;
-PSW #127 came in for a shift on a specified date, while they were supposed to be off pending the outcome of the home's investigation; and
-the incident was not reported to the Director until two days after the incident had occurred.

Upon reviewing the series of events, the Inspector inquired if the Administrator and Co-DOC believed that the home’s actions protected residents from the potentially neglectful care of PSW #127. The Administrator and Co-DOC acknowledged that the home failed to protect residents from neglect.

The severity of this issue was determined to be a level three, as there was actual harm/risk to resident #021, and the other residents of the home. The scope of the issue was a level one, as it only related to one resident reviewed. The home had a level three compliance history, as they had related non-compliance with this section of the LTCHA that included:

-a voluntary plan of correction (VPC) issued July 11, 2016, (#2016_414110_0005). (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 18, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7 th day of February, 2019 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by TIFFANY BOUCHER (543) - (A1)

Service Area Office / Bureau régional de services : Sudbury Service Area Office