Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2019	2019_746692_0028	013393-19, 016098-19, 017063-19	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

SHANNON RUSSELL (692)

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): October 21-25, 2019.

The Following intake(s) were inspected upon during this Critical Incident System Inspection:
-One log, which was related to a critical incident that the home submitted to the Director regarding an incident of visitor to resident abuse;
-One log, which was related to a critical incident that the home submitted to the Director regarding a fall of a resident, which resulted in a significant change in the resident's status; and,
-One log, which was related to a critical incident that the home submitted to the Director regarding a missing resident with injury.

A Follow Up Inspection #2019_746692_0029 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Care Services Coordinator (CSC), Interim Administrator, Director of Care (DOC), Resident Family Services Coordinator (RFSC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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

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

2 WN(s)
2 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	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. 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, for a incident that caused injury to a resident, resulting in a significant change in the resident's health status. A review of the CIS report indicated that resident #004 had sustained a fall the previous day, had been transferred to the hospital, where they were admitted with an significant injury.

The Inspector reviewed resident #004's health care records, identifying a focus of "Risk for falls", in their care plan that had been in effect at the time of the fall, which indicated that an identified intervention was to be implemented for resident safety and that staff were to ensure that the identified intervention was in place and functioning. A review of resident #004's electronic progress notes, identified a documented note, completed by Registered Practical Nurse (RPN) #104, which indicated that the identified intervention had not been in place at the time of the fall. A further review of the progress notes identified documentation, completed by RPN #102, dated the day following the fall, indicating that it had been unknown as to why the identified intervention had not been in place at the time of the fall.

The Inspector reviewed the home's policy "Resident Rights, Care and Services – Plan of Care", last revised September 24, 2019, which indicated that staff were to ensure that care was provided to the resident as specified in their plan of care.

The Inspector interviewed Personal Support Worker (PSW) #108, who indicated that staff were to review the resident's care plan and Kardex on Point Click Care (PCC), in order to know what care needs they required. PSW #108 indicated that resident #004 had been identified as a fall risk, and staff were to ensure that they had the identified intervention in

place, as a fall prevention intervention.

During separate interviews with RPN #104 and #102, they both indicated that staff were to review the resident’s care plan on PCC in order to know what care needs they required, and staff were to provide the care to the residents as indicated in the resident’s care plan. Both RPN #104 and #102 identified that resident #004 had been identified as a fall risk and they had recently implemented that the identified intervention was to be in place and functioning. RPN #104 indicated that they had been the registered staff that had found that resident #004 had fallen, and that they had documented that the identified intervention was not in place at that time. RPN #102 identified that they had documented that the identified intervention had not been in place the previous day, when resident #004 had fallen.

In an interview with Registered Nurse (RN) #107, they indicated that staff were to review the resident’s care plan and Kardex on PCC, which identified what interventions were to be implemented for that resident. Together, RN #107 and the Inspector reviewed resident #004’s care plan and progress notes from the time of the fall. RN #107 indicated that resident #004 was to have the identified intervention in place, as a fall prevention intervention, as per their care plan. RN #107 indicated that the documentation identified that the identified intervention was not in place when resident #004 had fallen, and it should have been.

In an interview with the Interim Administrator, who was the Director of Care (DOC) at the time of the fall, they indicated that staff were to follow the resident’s care plan when providing care. The Interim Administrator indicated that staff were to ensure that the identified intervention was in place while resident #004, and that when the resident fell on the identified date, the identified intervention had not been in place. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 was complied with.

A CIS report was submitted to the Director on an identified date, for an allegation of visitor to resident abuse. A review of the CIS report identified that the Substitute Decision Maker (SDM) of resident #003 had threatened resident #002.

Emotional abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

The Inspector reviewed the home’s internal investigation notes, identifying that while the SDM of resident #003 was in the home, they had threatened resident #002. The SDM of resident #003 was spoken to by the Administrator and DOC after the reported incident had occurred, reviewing the abuse policy, emphasizing that any form of abuse to the residents by anyone was not tolerated by the home. The investigation notes further indicated that the police were contacted in response to the incident.

A review of the home’s policy titled, “Resident Rights, Care and Services – Abuse and Neglect - Zero - Tolerance Policy for Resident Abuse and Neglect, version 3”, last revised April 25, 2019, indicated that the home had implemented a zero-tolerance of any form of abuse by any person interacting with residents, including all employees, volunteers, contracted staff, resident, and families.

During an interview with the Resident Family Services Coordinator (RFSC), they indicated that upon admission of residents their SDM(s) were provided with an Admission package, which included the home's Abuse and Neglect policy. The RFSC identified that they recalled that they had reviewed the policy with the SDM of resident #003. Together, the RFSC and the Inspector reviewed the admission package document, in which the SDM of resident #003 had signed when the resident had been admitted. The RFSC identified that by signing the document, the SDM had acknowledged that they had understood the contents, and that any type of abuse towards residents would not be tolerated.

During an interview with PSW #105, they described the incident involving the SDM of resident #003. PSW #105 indicated that resident #002 had been upset after the incident.

During separate interviews with RPN #104 and RN #107, they indicated that they recalled the incident in which the SDM of resident #003 had threatened resident #002.

In an interview with the Interim Administrator, who was the DOC at the time of the incident, they identified that SDM(s) and visitors were to follow the abuse policy, and that abuse of any type towards residents was not tolerated by the home. The Interim Administrator, indicated that the SDM of resident #003 had not complied with the home's zero-tolerance of abuse. [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 home's written policy to promote zero tolerance of abuse is complied with, to be implemented voluntarily.

Issued on this 4th day of November, 2019

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

Original report signed by the inspector.