Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: September 27, 2024
Inspection Number: 2024-1033-0002
Inspection Type: Complaint Critical Incident
Licensee: Jarlette Ltd.
Long Term Care Home and City: The Villa Care Centre, Midland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9-13, 16-17, 2024

The following intake(s) were inspected:

- Two intakes related to outbreaks of infectious disease;
- Two intakes related to falls;
- One complaint related to outbreak management;
- Two intakes related to resident care concerns;
- One intake related to alleged neglect of a resident by staff.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care-Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a specific resident, collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were integrated and were consistent with, and complemented each other.

Rationale and Summary
The physician ordered a diagnostic test for the resident.

A Registered Practical Nurse (RPN) and an Registered Nurse (RN), both identified that they were unable to complete the physicians order in a timely manner.

Co-Director of Care (Co-DOC) and the Director of Care (DOC) indicated that by causing a delay with the completion of diagnostic testing, it would delay the provision of the appropriate medical interventions.

There was risk to the resident when there was a delay in completing the diagnostic testing as ordered by the physician.

Sources: Complaint intake; the residents health care records; and interviews with the complainant, the DOC, and other staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

A) The licensee has failed to comply with the falls program for an identified resident after they had sustained a fall, resulting in them hitting their head.

In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11 (1) (b), the licensee was required to ensure that the falls prevention and management program must, at a minimum, provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the Long-Term Care Homes (LTCH) policy, that identified registered staff were to consider whether to hold specific medications until the resident had been assessed for head injury and the physician had provided orders. As well, the policy indicated the physician and substitute

decision maker (SDM) were to be notified at the time of the potential injury.

Rationale and Summary
The resident had sustained a witnessed fall and hit their head. Further review indicated that resident had a medication that had not been held when the resident hit their head.

Registered staff, Co-DOC and the DOC all stated that the homes policy had indicated for registered staff to contact the physician. The registered staff member identified that they had not contacted the physician at the time the resident was witnessed to have hit their head, or the SDM.

There was risk to the resident by the registered staff not complying with the LTCHs policy.

Sources: Critical Incident (CI) report and complaint intake; the resident's health care records; the LTCH's policy; and interviews with the complainant, the DOC, and other staff.

B) The licensee has failed to comply with the falls program for a resident after they had sustained an unwitnessed fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the falls prevention and management program must, at a minimum, provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the LTCH policy implemented by the licensee, that identified all unwitnessed falls will result in a Head Injury Routine (HIR) being initiated, unless the resident was capable of reliably communicating that they had

not hit their head.

Rationale and Summary
Another identified resident had sustained an unwitnessed fall, resulting in a significant change in their status. A review of the residents health care records identified that registered staff had not initiated HIR monitoring following the unwitnessed fall.

Registered staff indicated the HIR monitoring should have been initiated post fall, as per the LTCHs policy. Co-DOC identified that the registered staff should have initiated HIR monitoring.

There was risk to the resident by the registered staff not complying with the falls policy, to ensure they monitored the resident for potential concerns.

Sources: CI report; the residents health care records; the LTCH's policy; and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Infection prevention and control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee did not ensure routine practices related to hand hygiene were followed in the IPAC program as required under the IPAC Standard issued April 2022, last revised September 2023.

Rationale and Summary
During the inspection, multiple staff from various departments and units within the home were observed not to be completing hand hygiene, including during the four moments of hand hygiene.

The IPAC Lead confirmed staff were required to preform hand hygiene at the four moments of hand hygiene, and if this was not completed, identified that the staff would not be following the IPAC program.

Sources: Inspector observations, IPAC Standard for Long-Term Care Homes (effective April 2022, revised September 2023), and interviews with the IPAC Lead and other staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition,

inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee had failed to ensure that the Director was notified within three business days when an identified resident had sustained a fall, which resulted in a significant change in their status.

Rationale and Summary
The resident had sustained a fall on a specific date. The following day the resident had a change in their status. The LTCH had not notified the Director until a week later.

Sources: CI report; the residents health care records; the LTCH's policy; and interviews with the DOC and other staff.

COMPLIANCE ORDER CO #001 Dietary services and hydration

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 15 (2)
Dietary services and hydration
s. 15 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Develop and implement an auditing process for the identified home area to ensure residents are provided with the correct food texture and fluid consistency, and to ensure any additional requirements such as use of straws or specialized devices, are appropriate.

    a) The audits must be completed at a minimum of weekly for four weeks, and capture the breakfast, lunch, and supper meal.

    b) The home shall analyze the results of the audit, identify trends, and provide retraining to correct any deficiencies.

    c) Documentation of the audit, completed analysis, and any corrective action implemented must be maintained and made available to the Inspector(s) upon request.

Grounds

The licensee has failed to ensure that a specific resident was provided with fluids that were safe for the resident.

Rationale and Summary

A staff member was assisting a resident with their meal, and identified they had provided a specific consistency to the resident, which was different from their diet order. The Registered Dietitian (RD) indicated providing the specific consistency to the resident and not following the diet order, would have been high risk to the resident.

The Administrator acknowledged providing the resident the incorrect consistency would have not been in keeping with safe feeding practices.

There was actual risk to the resident when the staff member provided them the incorrect consistency.

Sources: CI report; progress notes and assessments for the resident; the residents diet order summary; and interviews with the Administrator, and other staff.

This order must be complied with by November 8, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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