Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2014	2014_276537_0061	T-000106-14	Resident Quality Inspection

Licensee/Titulaire de permis

JARLETTE LTD.
689 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

NANCY SINCLAIR (537), PATRICIA VENTURA (517), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 10, 11, 12 and 13, 2014

During the course of the inspection, the inspector(s) spoke with 40 Residents, 3 Family Members, the Administrator, Co-Director of Resident Care, Resident and Family Services, Coordinator, Nutrition Manager, Education Coordinator, Environmental Services Supervisor, Life Enrichment Coordinator, Resident Assessment Instrument(RAI) Coordinator, 3 Registered Staff, 10 Personal Support Workers, 2 Housekeeping Staff and a Dietary Aide.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas, recreational activities and care provided to residents, reviewed health records and plans of care for identified residents, reviewed policies, procedures and related training records, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. O. Reg. 79/10, s. 15 (1).

On November 10, 2014, the beds of 2 identified residents were observed to have a particular mattress system and both residents used side rails when in bed.

Interview with the Administrator indicated that an external company was hired to complete bed assessments which included entrapment zone. The Administrator also indicated that the company did not complete any assessment to the identified bed systems. The Administrator confirms that no additional steps were taken to assess the safety of the residents using this particular bed system.

The Administrator confirmed that it is the expectation that the resident is assessed and the bed system evaluated for all residents to minimize risk to the resident. [s. 15. (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 that ensures that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids are being served at a temperature that is both safe and palatable to the residents.

A record review of a dining room food temperature tracking sheet revealed that food temperatures were significantly below the required temperature ranges noted on the homes record at the time of service.

39/41 (95%) of evening dishes served between October 1, 2014 and October 6, 2014 were not at the homes required temperature at the time of service.

Interview with the Dietary Manager revealed ongoing performance issues related to the cook serving the food in the 3rd Floor dining room for evening meals indicating the cook had not reported the temperature discrepancy to the Dietary Manager or implemented corrective actions and had continued to serve the food at less than palatable temperatures to the residents.

The Dietary Manager confirmed that the expectation was that all food would be served at the required temperatures, and that corrective actions would be taken to ensure the food was at a temperature that is both safe and palatable to the residents. [s. 73. (1) 6.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

a) On November 10, 2014 at 0900 hours in a dining room, observations revealed a Personal Support Worker standing to assist four residents with eating.

An interview with the Personal Support Worker verified she had stood to assist the four residents and it is the homes expectation that all staff are to sit while they assist a resident with eating.

The Administrator and Nutrition Manager confirmed that it is the expectation that staff will be seated when assisting a resident to eat.

b) On November 10, 2014 in a dining room, observations revealed a Personal Support Worker assisting a resident with eating while the Personal Support Worker was seated in the residents mobility device.

An interview with the Personal Support Worker verified she was seated in the residents mobility device and the homes expectation is that staff assisting residents with eating are to be seated in a chair to safely assist the resident.

The Administrator and Nutrition Manager verified that it is the expectation that staff be seated in a chair to safely assist the resident. [s. 73. (1) 10.]

3. The licensee has failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking.

On November 10, 2014 in a dining room at 0900 hours, observations revealed a Personal Support Worker assisting four residents with eating.

An interview with the Personal Support Worker verified it is the homes expectation to only assist two residents at a time with eating or drinking.

The Administrator and Nutrition Manager confirmed it is the expectation to only assist two residents at a time with eating or drinking. [s. 73. (2) (a)]

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 food and fluids are being served at a temperature that is both safe and palatable to the residents, that has proper techniques to assist residents with eating, including safe positioning of residents who require assistance and to ensure that no person simultaneously assists more than two resident who need toal assistance with eating or drinking, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

An identified resident had a fall in October 2014. The Registered Staff placed a referral for a physiotherapy assessment on the same day as part of the follow-up for the fall.

Health record review on November 13, 2014 at 0930 hours for this resident revealed there was no documentation to indicate a physiotherapy assessment had taken place after the fall.

Interview with the Co-Director of Resident Care revealed the expectation was that the physiotherapist assess the resident within one week of receiving the referral.

Interview with the Administrator revealed the Restorative Care Coordinator contacted the physiotherapist on November 10, 2014 to request the assessment of this resident and the physiotherapist completed the assessment on that day.

The Administrator confirmed the assessment of November 10, 2014 was not timely and not documented in the resident's health record. [s. 30. (2)]

Issued on this 18th day of November, 2014

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