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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 2, 2015	2015_334565_0011	T-478-13	Complaint

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

MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 28, 29, June 1, 2, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DORC), registered staff, personal support workers (PSWs) and family member.

The inspectors conducted a tour of the resident home areas, observations of staff and resident interactions, provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	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 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 is provided to the resident as specified in the plan.

Record review of resident #31's plan of care indicated the resident required one-person limited assistance for toileting. It further indicated the resident had been suffering from blackouts and would self-transfer himself/herself off the toilet. Staff should not leave the resident unattended on the toilet as it was unsafe for the resident.

Resident #31 fell on an identified date in the bathroom hitting the wall and sustained an injury. Recorded review indicated the fall was unwitnessed and the resident was unattended while he/she was on the toilet.

Interviews with the DORC and a PSW confirmed the resident was assisted to the bathroom and he/she was left unattended on the toilet, and subsequently the resident fell in the bathroom. The DORC further confirmed staff did not supervise the resident on the toilet as specified in the plan of care. [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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the home's policy titled "Fall Management and Prevention", effective date: May 2007, indicated a specified assessment for the identified injury would be used to assess a resident after a fall. Further review of an identified policy indicated staff should complete an assessment record at the following intervals after a fall:
- Every 30 minutes for two hours
- Every hour for next four hours
- Every two hours for next six hours
- Every four hours for the next 12 hours
- Daily for one week

Record review revealed resident #31 fell on an identified date in the bathroom hitting the wall and sustained an injury. The resident was sent to the hospital on the next morning. A review of the identified assessment record indicated the assessment was conducted at the following time:
- On the identified date at 10:52 a.m., 11:00 a.m., 11:30 a.m., 12:30 a.m., 1:00 p.m., 1:30 p.m. and 11:15 p.m.
- On the next day at 3:05 a.m., 6:20 a.m. and 7:15 a.m.

Interview with the DORC confirmed the identified assessment for the resident was not completed between 1:30 p.m. and 11:15 p.m. on the identified date according to the home's protocol. [s. 8. (1) (b)]

Issued on this 21st day of July, 2015

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

Original report signed by the inspector.