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

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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 9, 2015	2015_297558_0009	T-1747-15	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

BARBARA PARISOTTO (558), ANN HENDERSON (559), MATTHEW CHIU (565)

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): May 19, 20, 21, 22, 25, 26, 28, 29, June 1, 2, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DORC), co-director of resident care (co-DORC), resident and family services coordinator (RFSC), environmental services supervisor (ESS), resident assessment instrument (RAI) coordinator, education coordinator, life enrichment coordinator, restorative care coordinator, nutrition manager (NM), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), health care aides (HCA), dietary aides (DA), housekeepers, maintenance staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

11 WN(s)
3 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review and staff interviews revealed on an identified date and time resident #007 experienced a fall while being transferred by two staff from the bed using a sit-to-stand lift. A review of the progress notes revealed the following intervention was implemented as a result of the post-fall assessment:

- Staff to use full lift when resident feeling weak and/or non-compliant until assessed by back care team as per safety measures.

Record review and interview with the restorative care coordinator confirmed a referral

and the assessment of resident #007 by the back care team did not occur. [s. 6. (4) (a)]

2. 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 the Master Diet List and a family interview revealed resident #010 dislikes a specified beverage and is not to be offered this beverage as an intervention. On May 21 and 22, 2015, staff members gave resident #010 the specified beverage to drink. Staff member #108 confirmed the resident is given this beverage regularly to drink at meal times.

An interview with staff #126 confirmed the PSWs failed to follow the Master Diet List for the resident where it states the resident is not to receive this specified beverage as an intervention and the resident does not like this beverage. [s. 6. (7)]

3. The licensee has failed to ensure that when the resident is reassessed that the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

A review of the plan of care for resident #013 specified a type of personal assistive device required and the date of replacing this device.
A review of the physician's medication review for April 1-June 30, 2015, for resident #013 specified the type of personal assistive device required and the date of replacing this device. The physician's order did not match that specified in the plan of care.
Record review of the progress notes and interviews with registered staff #114 and #116 revealed the resident was using a personal assistive device different that that specified by the physician or plan of care over the past two months.

An interview with the co-DORC confirmed the plan of care was not revised when the resident's needs changed. [s. 6. (10) (b)]

4. A family interview revealed resident #001's eye glasses were missing.

A review of the plan of care stated:
- Wears glasses at all times. Ensure glasses are clean and adorned.

Interviews with staff #104 and #135 revealed resident #001 used to wear glasses prior to the resident's health status changing.

An interview with staff #104 confirmed the resident should be reassessed and the plan of care reviewed and revised to reflect the resident's current care needs and remove the intervention if eye glasses are no longer necessary. [s. 6. (10) (b)]

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 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. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care.

Observations of resident #002, #014 and #015's beds revealed high mattress sides and a dip in the middle of the mattress.
During an interview resident #002 stated "the mattress is rock hard, hurts my back in the morning and I'm stiff and have difficulty getting up". Resident #014 stated "the mattress is hard and uncomfortable, and I was told they were Government Issue". Resident #015 stated "the mattress is very uncomfortable and has a dip in the centre; I need to use the rails to haul myself out of bed. I have complained but it has not been changed". Resident #015's family implemented a specified intervention to improve the comfort of the bed. Staff interviews confirmed residents had complained the new mattresses are uncomfortable.

The administrator revealed the home changed the mattresses last year and confirmed the mattresses are not comfortable to the residents. [s. 12. (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 the resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On May 29, 2015, the inspector observed personal protective equipment (PPE) door caddies hanging on the doors of three identified resident rooms. There was no isolation precaution signage informing staff or visitors of the precautions required.

An interview with the co-DORC revealed when contact precaution is indicated, a staff member should post isolation precaution signage on the door of the resident's room. The co-DORC confirmed the identified residents had infections that required contact precautions and registered staff had failed to post isolation precaution signage on the doors. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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 the plan, policy, protocol, procedure, strategy or system is complied with.

The written plan of care identified resident #016 as having pain in identified areas. During interviews on May 22 and 29, 2015, the resident identified pain in these areas. Review of the physician's orders and medication administration record revealed the resident is given routine pain medication and the resident has not received pain medication for breakthrough pain.

Record review identified the resident as having angry outbursts and reveals pain is usually the cause of the resident's behaviours. Staff have been directed to offer pain medication.

Staff interviews revealed the resident has pain in identified areas. RPN #111 asked the resident if he/she was in pain and the resident identified an area of pain.
Review of the pain management program policy, effective 09/06/2013, directs staff to assess and reassess residents when their pain is not managed.

An interview with the DOC confirmed resident #016's pain is not relieved and the resident has not been reassessed for pain management. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the home, furnishings and equipment are kept clean and sanitary.

On May 22, 28, and June 2, 2015, ambulation equipment for resident #011 and #018 were observed to be unclean.
Record review of the equipment cleaning schedule revealed the night PSWs had signed as having cleaned the equipment for resident #011 on May 23, 2015, and resident #018 was scheduled but not signed as having been cleaned on May 22, 2015.

An interview with the DORC revealed night PSWs are directed to clean the residents ambulation equipment with the steam cleaner and sign the equipment cleaning schedules. The DORC confirmed the identified residents' ambulation equipment were unclean. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Record review indicated resident #001 was admitted to the home on an identified date and the six week interdisciplinary care conference was held accordingly.

A record review and interview with the RFSC confirmed resident #001 did not have an annual interdisciplinary care conference in 2014. [s. 27. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The home uses an assessment instrument in PCC to assess a resident's continence status. Record review of resident #001's continence assessment, completed on a specified date, indicated the resident was continent of bladder. Further review of the resident's minimum data set (MDS) assessment, completed on a specified date, indicated the resident was occasionally incontinent of bladder and there was no continence assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions completed for the resident.

Interviews staff #104 and #112 confirmed the resident's health conditions had changed and he/she became occasionally incontinent of bladder and confirmed the resident did not receive a continence assessment to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the 2014 resident and family satisfaction surveys revealed the use of the abaqis stage 1 resident and family interview questions with additional questions measuring overall satisfaction with the facility and the likelihood of recommending this facility.

An interview with the administrator revealed the abaqis quality management system has replaced the home's previous resident and family satisfaction surveys and the abaqis system does not measure the level of satisfaction related to services and programs such as physiotherapy, continence care and skin and wound care in the home. [s. 85. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented to ensure that the sinks and grab bars are maintained.

On May 20 and June 1, 2015, the washroom grab bar in room #226 was observed to be loose. On May 21 and June 1, 2015, the washroom sink in room #224 was observed to have running water which could not be turned off.
A record review and interview with staff #133 revealed the identified maintenance items had not been documented in the maintenance repair book. The maintenance repair book is the method used to communicate repairs to the maintenance staff.

An interview with the maintenance staff confirmed they were unaware of the maintenance items prior to the inspection and were informed of the items that required repair by staff #133. [s. 90. (2) (d)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

A family interview revealed resident #001's eye glasses have been missing for approximately two months and this was reported to staff. Staff interviews revealed the resident owns eyeglasses and had not been wearing the eye glasses since the resident experienced a change in health status. On June 2, 2015, staff members were unable to locate the eye glasses in the resident's room.
A record review of progress notes, the communication binder and the Concerns/Complaints binder did not identify missing eye glasses for resident #001.

The DORC confirmed a concern/complaints form was not initiated and an investigation for resident #001's missing eye glasses did not occur. [s. 101. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On May 25, 2015, at the lunchtime medication pass, resident #041 received an identified medication as ordered. The RPN revealed to the inspector resident #041 did not have available a personal supply of the identified medication and the registered staff were borrowing the medication from resident #042's PRN medication card.

The RPN revealed resident #041 had been on a ten day trial of the medication, the order was reassessed and faxed to the pharmacy on May 23, 2015. As a result tablets of the identified medication were used from resident #042 for resident #041.

Two RPNs revealed the practice of borrowing from another resident does occur and neither nurse was sure if resident #42's borrowed medication were replaced.

Review of the policy Ordering and Receiving Medication 2.3 revision date July 2014, states:
- When the pharmacy is closed staff are to contact either the satellite pharmacy or the on-call pharmacist.
The RPN was unaware pharmacy could arrange for a delivery of a medication on a Saturday.

The RPN contacted the clinical pharmacist on May 25, 2015, for clarification and confirmed the home had failed to ensure the drug dispensed by the pharmacy was used for the resident. [s. 131. (1)]

Issued on this 10th day of August, 2015

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

Original report signed by the inspector.