Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
~~Aug 4, 2011~~ April 27, 28, 2011	2011_102132_0011	Critical Incident

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

ROSEMARY LAM (132)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Registered staff, personal support workers and members of the management team, including the Administrator, Director and assistant Director of Care.

During the course of the inspection, the inspector(s) Examined wheelchair equipment, reviewed resident files, inspected various common areas and observed staff providing transport to and from dinning room

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits sayants :

1. an identified resident's plan of care did not provide clear direction to manage ongoing safety risk related to an incident which resulted in a resident injury.
- Care strategies to prevent further incident as outlined in critical incident report submitted to MOH were not included in the plan of care.
- Inspector observed resident with ongoing risk on April 27, 2011 [s.6(1)(c)

2) An identified Resident's plan of care does not provide clear direction on specific requirement for a therapeutic surface according to prevailing practices.
o The plan of care directed staff to use med brief, and not the specific requirement for Dry-Flo incontinent pad or non-plasticized breathable briefs.
o The plan of care does not provide direction on which one of the three air level settings should be used for the therapeutic surfaces.
o the plan of care identified resident's prefer up time as 0700am and bedtime as 6:45pm. The prevailing practice of ensuring resident is not off the surface for more than 2 hours at a time for optimal effect was not available in the plan of care. Resident was observed to be up in wheelchair from 0800am to 7pm (11 hr). Resident's coocynx worsened on April 21, 2011 with possible infection with scant serous drainage and increased in size to 2x1cm from 1.5x0.5cm.[s.6(1)(c)]

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 with ensuring the plan provides clear direction to staff and others who provide direct care to the resident., to be implemented voluntarily.

Issued on this 4th day of August, 2011

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