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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2018	2018_657681_0027	024166-17, 001786-18, 007301-18, 011516-18, 026280-18	Complaint

Licensee/Titulaire de permis

Jarlette Ltd.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

STEPHANIE DONI (681), RYAN GOODMURPHY (638), TIFFANY BOUCHER (543)

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): November 26 - 30, 2018, and December 3 - 7, 2018.

The following intakes were inspected on during this Complaint inspection:

- Four intakes related to complaints submitted to the Director regarding resident care concerns.

A Follow up inspection #2018_657681_0026 and a Critical Incident System inspection #2018_657681_0028 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Director of Care (Co-DOC), Staff Educators, Nutrition Manager, Resident and Family Services Coordinator, Restorative Care Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Laundry staff, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Food Quality
Nutrition and Hydration
Pain
Personal Support Services

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

- **3 WN(s)**
- **2 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	Légende 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks.

A complaint was submitted to the Director, which identified that a specified incident occurred involving resident #005. The complainant stated that the resident was assessed as being of a particular safety risk and this was brought to the attention of the home when the resident was admitted.

Inspector #638 reviewed resident #005's health care record and identified a progress note written by RPN #105 at the time of resident #005's admission to the home. The progress note identified that the resident was of a particular safety risk and that a specific intervention had been implemented. The Inspector also identified a specified assessment that was completed prior to the resident's admission, which indicated that similar incidents had occurred prior to the resident's admission to the home.

Inspector #638 reviewed a progress note written on a specified date, which identified that a specified incident had occurred. A second progress note was identified that indicated that a second similar incident had occurred on the same specified date.

The Inspector reviewed the resident's care plan and was unable to identify any documentation to indicate that the resident was of a particular safety risk before or after the incident had occurred.

In an interview with Inspector #638, PSW #103 indicated that a resident's safety risk would be identified in the resident's care plan. The PSW stated that care plans were available to all direct care staff so they could remain aware of the resident's needs.

During an interview with RPN #108, they indicated that it would be identified in a

resident's care plan if they were at a particular safety risk. The RPN stated that resident care plans were accessible to all staff and this was what staff referred to for specific care interventions related to resident safety.

The home's policy titled "Resident Rights, Care and Services – Plan of Care – 24 Hour Plan of Care" last revised March 3, 2018, indicated that staff were to ensure that the plan of care included, within 24 hours, any risk the resident may have posed to themselves and any interventions to mitigate those risks.

In an interview with Inspector #638, the Administrator identified that resident #005 was assessed as a particular safety risk at their admission. Upon reviewing the resident's health care records, the Administrator stated that the resident's safety risk had not been identified within their plan of care. The Administrator indicated that the resident's safety risk should have been identified in the resident's plan of care since their admission, based on the specified assessment that had been completed prior to the resident's admission to the home. [s. 26. (3) 19.]

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 plan of care is based on, at a minimum, an interdisciplinary assessment of safety risks, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complainant submitted complaints to the Director on two specified dates, related to various resident care concerns, including medication administration errors.

In a telephone interview with resident #003's substitute decision-maker (SDM), they indicated that there had been several medication errors over a specified period of time.

Inspector #543 reviewed the medication administration errors for resident #003 and for two other residents, and identified the following:

A) On a particular date, resident #003 was administered the incorrect medication. While administering the resident's 1200 hour medications, the nurse administered another medication that was scheduled for 1700 hours.

On a particular date, the home was questioned by resident #003's SDM as to whether resident #003 had been given a specified medication. It was discovered that the medication had not been administered to the resident, but had been signed as being administered.

B) On a particular date, resident #023 self-administered a specified medication. The nurse prepared the medication and left it in resident #023's room. The nurse went to assist another resident and returned to find that resident #023 had self-administered the medication. Resident #023 complained of specified symptoms after taking the medication.

C) On a particular date, resident #016 was not administered a specified medication. Upon further review, it was identified that resident #016 was not administered this same medication on two previous occasions. The Administrator indicated that there had been a negative effect on resident #016's medical condition as a result of the missed medications.

In an interview with the Administrator and Co-DOC regarding the above medication incidents, they verified that medications were not administered in accordance with the directions for use specified by the prescriber for residents, #003, #023 and #016. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM, if any, or any person designated by the SDM and any other person designated by the resident, were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be so notified.

A complaint and CIS report were submitted to the Director regarding an allegation of staff to resident abuse. The CIS report indicated that resident #006 sustained injury after a specific intervention was used to transfer the resident.

During an interview with resident #006's SDM, they indicated that they were not advised of the injury that resident #006 sustained and that they only became aware of the incident when they visited resident #006 on a later date.

Inspector #681 reviewed the progress notes in resident #006's health care record. The Inspector was unable to identify documentation which indicated that resident #006's SDM was notified of the resident's injury when the incident occurred.

During an interview with PSW #122, they stated that resident #006's SDM should have been notified immediately about the incident, but they were not certain if this had occurred. PSW #122 stated that it was their understanding that resident #006's SDM had come to the home on a later date and had not been aware of what had occurred.

During an interview with RPN #123, they stated that a resident's SDM should be contacted with any change in the resident's status. RPN #123 stated that they worked the night of the incident and that they did not recall contacting resident #006's SDM. RPN #123 also stated that there was no documentation to support that resident #006's SDM was contacted at the time of the incident.

During an interview with the Co-DOC, they stated that resident #006's SDM was enacted and that they made all the decisions related to resident #006's care. The Co-DOC stated that, based on the available documentation, resident #006's SDM was not notified at the time the incident occurred. The Co-DOC stated that resident #006's SDM should have been contacted immediately. [s. 107. (5)]

Issued on this 31st day of December, 2018

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

Original report signed by the inspector.