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

Sudbury Service Area Office
159 Cedar Street Suite 403
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Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 20, 2019	2019_771734_0006	033330-18, 001608-19	Critical Incident System

Licensee/Titulaire de permis

Jarlette Ltd.
c/o Jarlette Health Services 711 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

JADY NUGENT (734), JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 5-8, 2019.

Two intakes were inspected upon during this Critical Incident System Inspection, both relating to a resident fall.

Follow-up inspection #2019_771734_0005 was conducted concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care, Restorative Care Coordinator, Resident Assessment Instrument Minimum Data Set (RAI MDS) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the resident was reassessed and the plan of care reviewed and revised at least every six months, or at any other time when care set out in the plan was not effective.

A Critical Incident System (CIS) report was submitted to the Director related to an incident, whereby resident #002 had a fall that resulted in a transfer to hospital and further resulted in a fracture to an area of their body.

A review of the admission documentation by Inspector #647 for resident #002 indicated that the resident had been identified as having a history of falls, and had been a fall risk. A review of the falls history for resident #002 after admission to the home indicated a specific number of falls in various locations throughout the home, with some involving sustained injuries.

A review of the electronic fall assessment notes for these falls did not include any new interventions, and indicated to "continue with current plan of care".

During a review of the plan of care for resident #002, the care plan identified that a focus of falls and related interventions had been initiated after the resident had returned from the hospital.

A further review of the current plan of care for resident #002 indicated that additional interventions had been added to the care plan later on, after resident #002 had a specific number of additional falls that included a second sustained fracture.

The home's policy titled "Resident Rights, Care and Services - Required Programs – Falls Prevention and Management – Program", Version 5, last revised October 22, 2018, indicated that any resident who has fallen, has the plan of care updated to reflect falls risk and factors that contributed to the fall, measurable goals, interdisciplinary focus, and specifics to guide the provision of care.

During interviews with Personal Support Workers (PSWs) #100 and #111, they indicated that during the numerous falls with resident #002, they continued with the same interventions. These PSWs further indicated there was no communication of additional interventions.

During interviews with Registered Practical Nurses (RPNs) #112, #119, and the Resident Assessment Instrument Minimum Data Set (RAI MDS) Coordinator, they all indicated that any plan of care was to be revised at a minimum quarterly and also at any time specific interventions were not effective. Together with Inspector #647, they reviewed the current plan of care for resident #002 and acknowledged that the resident had several falls from the time of admission, and the plan of care had not been revised when current interventions were not effective.

During an interview with the Director of Care (DOC), Inspector #647 reviewed resident #002's current plan of care for falls. The DOC acknowledged their awareness of the frequency of falls for resident #002, however; indicated to the Inspector that they had been unaware that the current plan of care had not been revised for the interventions that had been no longer effective when the resident continued to fall. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for residents and communicated to the direct care staff within 24 hours of the resident's admission to the home that included any risks that resident may pose to them, including any risk of falls, and interventions to mitigate those risks.

A CIS report was submitted to the Director related to an incident whereby resident #002 had a fall that resulted in a transfer to hospital. Please see WN #1 for further details related to the CIS report.

Inspector #647 reviewed the progress notes that indicated resident #002, within 48 hours after admission, had lost their balance and fell.

A review of the admission documentation located in the chart for resident #002 indicated that the resident had been identified as having a history of falls and had been a current fall risk.

During a review of the 24 hour admission care plan for resident #002, it had been identified that a focus of falls had not been initiated until after the resident had returned from the hospital.

The home's policy titled "Resident Rights, Care and Services – Required Programs – Falls Prevention and Management – Program", Version 5, last revised October 22, 2018, indicated that "falls risk is to be identified and a care plan developed immediately, related to the risk if the resident was a new admission and/or resident/substitute decision maker identified falls as a problem/potential problem". This same policy further stated that "residents are asked on admission about falls history and same is documented (history of falls is the number one predictor of future falls)", and also stated that "residents are indicated to be high risk for falls on admission until further risk assessment is completed and appropriate interventions initiated to address admission risk".

During interviews with Personal Support Workers (PSWs) #100 and #111, they indicated that they follow the 24 hour admission care plan and the kardex, which they described as a condensed plan of care to identify all activities of daily living (ADLs) and all risk factors that PSWs need to be aware of in order to provide the resident with care.

During interviews with RPNs' #112, #119, and the RAI MDS Coordinator, they all indicated that the 24 hours admission care plan was initiated upon admission. The nurse that initiated the care plan was required to use any admission documentation that was provided to the home and any other applicable documentation that was provided. Together with Inspector #647, they acknowledged that the admission related documents all identified resident #002 as being a fall risk and should have been identified on the 24 hour admission care plan.

During an interview with the DOC, Inspector #647 reviewed resident #002's 24 hour admission care plan and the DOC acknowledged that resident #002 had been identified as a fall risk on three documents that should have been utilized to initiate the 24 hour

admission care plan. The DOC indicated that all risk factors that included the fall history and fall risk were required to be in the 24 hour admission care plan. [s. 24. (2) 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 to ensure that a 24 hour admission care plan is developed for residents and communicated to the direct care staff within 24 hours of the resident's admission to the home that includes any risks the resident may pose to himself or herself, including any risk of falls, and interventions to mitigate those risks, to be implemented voluntarily.

Issued on this 26th day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JADY NUGENT (734), JENNIFER BROWN (647)
Inspection No. / No de l'inspection :	2019_771734_0006
Log No. / No de registre :	033330-18, 001608-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 20, 2019
Licensee / Titulaire de permis :	Jarlette Ltd. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	The Villa Care Centre 689 Yonge Street, MIDLAND, ON, L4R-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jill Wismer

To Jarlette Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The Licensee must be compliant with s. 6. (10) of the Long-Term Care Home Act (LTCHA).

The licensee shall prepare, submit and implement a plan to ensure that a resident that continues to fall, has their plan of care reviewed and revised every six months, or at any other time when the care set out in the plan is not effective.

The plan must include, but is not limited, to the following:

- Ensure that resident #002 is reassessed and the plan of care reviewed and revised when the care set out in the plan is not effective;
- Review the care plans for all residents who are at high risk of falls to ensure the care plans reflect the falls prevention interventions and are reviewed and revised when the care set out in the plan has not been effective;
-Develop, implement, and maintain records for an auditing process to ensure that when a resident is identified as a high risk for falls, the plan of care is reviewed and revised when the plan of care is not effective.

Please submit the written plan for achieving compliance for inspection #2019_771734_0006, CO #001 to Jady Nugent, LTC Homes Inspector, MOHLTC, by email to SudburySAO.moh@ontario.ca by April 3, 2019.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months, or at any other time when care set out in the plan was not effective.

A Critical Incident System (CIS) report was submitted to the Director related to an incident, whereby resident #002 had a fall that resulted in a transfer to hospital and further resulted in a fracture to an area of their body.

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The severity of this issue was determined to be a level 3, as there was actual harm to the resident. The scope of the issue was a level 1 as it was an isolated incident. The home had a level 3 compliance history with 1 or more related non-compliance in last 36 months with this section of the Act that included:
-Voluntary plan of correction (VPC) issued July 5, 2015 (2015_297558_0009) (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 26, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jady Nugent

Service Area Office /
Bureau régional de services : Sudbury Service Area Office