Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2020	2020_771609_0010	009975-20	Complaint

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

CHAD CAMPS (609)

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): June 16-18, 2020.

The following was inspected upon during this Complaint inspection:
-One intake related to a complaint submitted to the Director regarding the care of a resident.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Restorative Care Coordinator (RCC), Care Services Coordinator, Resident and Family Services Coordinator, Nurse Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Third Party Oxygen Consultant (Consultant), residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, as well as 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)**
- **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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Director related to the care provided to resident #001 in the home during a specific time frame.

a) A review of resident #001's health care records for the specified time frame found that two incidents involving the wellbeing of the resident had occurred. During both incidents staff identified that the resident required a specific intervention be implemented.

A review of resident #001's plan of care revision history found that the specified intervention was resolved previously by an identified staff member.

A review of the home's policy titled "Resident Rights, Care and Services- Plan of Care-Plan of Care (Care Planning)" last revised September 24, 2019, indicated that the resident's SDM would be given the opportunity to participate fully in the development and implementation of the resident's plan of care.

During an interview with resident #001's SDM, they indicated that they were notified by staff that they would be implementing the specified intervention at the time of the two incidents. The SDM indicated that they were never notified that the specified intervention was discontinued prior to the two incidents. Had they been notified, they would have refused to have the specified intervention removed.

During an interview with the identified staff member, they described conducting an assessment of resident #001 prior to the two incidents and felt the specified intervention was no longer needed and discontinued the intervention. The identified staff member verified that the resident's SDM did not participate in the home's decision to discontinue the specified intervention, but should have been.

b) During a review of resident #001's health care records, another incident involving the wellbeing of the resident, occurred on a particular day.

A review of the resident #001's progress notes found that on the particular day, that the identified staff member re-implemented the resident's specified intervention.

A further review of resident #001's health care records between the incident time frames,

found no documentation of who, when or why the resident's specified intervention was discontinued, nor any documentation to support that the resident's SDM participated in the decision to remove the specified intervention.

During an interview with RPN #106, they verified that any removal of the specified intervention should be documented. However, they acknowledged that a resident's SDM usually did not participate in the home's decision to remove the specified intervention.

During an interview with the identified staff member, a review of resident #001's health care records was conducted. They verified that the specified intervention was discontinued by someone between the incident dates, that there was no documentation of who, when or why the resident's specified intervention was discontinued nor any documentation to support that the resident's SDM participated in the decision to remove the specified intervention.

c) During an interview with the identified staff member, a review of their assessments was conducted, which found that resident #003 and resident #004 had a specified intervention discontinued on particular days.

A review of the health care records of resident #003 and resident #004 were conducted with the identified staff member who verified that their SDMs did not participate in the decision to discontinue the specified interventions, but should have been. [s. 6. (5)]

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 resident's SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A complaint was submitted to the Director related to related to the care provided to a resident in the home.

a) On a particular day, Inspector #609 observed oxygen equipment and supplies being used in the home.

A review of the oxygen equipment and supply document titled "Resource Guide for Long Term Care and Retirement Homes" copyright 2015, required:

-Concentrators be unplugged weekly, wiped down with a clean cloth and plugged back in;
-Concentrator filters (if applicable) be removed, cleaned weekly, rinsed and dried thoroughly before replacing;
-Nasal canula tips be wiped, cleaned, rinsed daily and be replaced every two weeks or sooner if damaged; and
-Oxygen tubing be wiped weekly with a clean damp cloth and be replaced every three months or sooner if damaged.

During an interview with RPN #107, they were unable explain any procedure for the checking, cleaning or replacing of the oxygen supplies or equipment. The RPN indicated that in the past there used to be an Electronic Medication Administration Record (EMAR) task for weekly oxygen maintenance and/or be outlined in the registered staff's night shift duties.

Both the Inspector and RPN #107 reviewed the EMAR tasks as well as reviewed the home's registered staff's night shift duties binder and found no direction to staff on the checking, cleaning or replacement of oxygen supplies or equipment.

b) During an interview with the Third Party Oxygen Consultant (Consultant) for the home, a review of "Resource Guide for Long Term Care and Retirement Homes" was

conducted. The Consultant verified that the guide was considered the manufacturer's instructions for oxygen supplies and equipment in the home. They described how the staff were required to follow the maintenance schedule for the oxygen supplies and equipment used the home.

The Consultant further described how not following the maintenance schedule could result in uncomfortable, hardened tubing that could harbour infectious agents. Tubing if not changed as per the maintenance schedule could lead to cracked, brittle tubing and a decrease in the oxygen reaching the resident.

During an interview with the Acting Director of Care (DOC), they verified oxygen equipment and supplies were used in the home.

During the same interview with the DOC, a review of health care records and the "Resource Guide for Long Term Care and Retirement Homes" were conducted. The DOC acknowledged that there was no direction to staff on the checking, cleaning or replacement of oxygen supplies and equipment for residents requiring oxygen in the home, but that there should be. [s. 23.]

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 all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

Issued on this 30th day of June, 2020

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

Original report signed by the inspector.