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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 9, 2013	2013_168202_0019	T-1841-12,T -1842-12	Complaint

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 26, 27, 28, 2013 and April 03, 04, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Co-Director of Care, Dietitian, Registered Nursing Staff, Personal Support Workers, Dietary Aide, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, observed meal and snack services, reviewed clinical records, reviewed the home's policies related to nutritional referrals, skin and wound care, continence care, reviewed staff educational records and staff schedules

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Nutrition and Hydration

Personal Support Services

Skin and Wound Care

Snack Observation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. [s.3.(1) 1]

Resident #001's plan of care directs staff to use a bed pan for toileting, monitor every 5 minutes while on bed pan and use for a maximum of 15 minutes at a time. Staff interviews and clinical record review revealed that resident #001 was found on the bed pan at an identified time on a night shift and had been placed on the bed pan during the evening shift at a time prior to 2300 hours.
Resident #003's plan of care directs staff to use a bed pan for toileting and monitor every 15 minutes while on bed pan. Staff interviews and clinical record review revealed that resident #003 was found on the bed pan on an identified date and time when staff brought resident #003's dinner to his/her room. Staff interviews and clinical record review indicate that resident #003 had been left on the bed pan for at least 45 minutes. [s. 3. (1) 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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #2: 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s.6.(7)]

Resident #004's written plan of care directs staff to provide no milk to drink intervention. On March 26 and 27, 2013 during the lunch meal service, the inspector observed resident #004 to be provided milk. An interview with an identified staff member revealed that resident #004 always receives milk at meal times. [s. 6. (7)]

2. Resident #001's plan of care directs staff to use a bed pan for toileting, monitor every 5 minutes while on bed pan and use for a maximum of 15 minutes at a time. Staff interviews and clinical record review revealed that resident #001 was found on the bed pan during an identified time on a night shift and had been placed on the bed pan during the evening shift at a time prior to 2300 hours.
Resident #003's plan of care directs staff to use a bed pan for toileting and monitor every 15 minutes while on bed pan. Staff interviews and clinical record review revealed that resident #003 was found on the bed pan at an identified time and date when staff brought resident #003's dinner to his/her room. Staff interviews and clinical record review indicate that resident #003 had been left on the bed pan for at least 45 minutes. [s. 6. (7)]

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 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff and is assessed by a registered dietitian.[s.50.(2)(b)(iii)(iv)]

A review of resident #003's clinical records identifies this resident as having altered skin integrity on an identified date. An interview with the Co-Director of Care and review of resident #003's clinical records confirmed that he/she was not assessed by a registered dietitian when exhibiting altered skin integrity. [s. 50. (2) (b) (iii)]

2. Resident #001's plan of care identifies this resident as having altered skin integrity on an identified date. Clinical record review and staff interviews confirmed that resident #001's altered skin integrity was not reassessed at least weekly.[s. 50. (2) (b) (iv)]

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Issued on this 9th day of April, 2013

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