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

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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
Sep 29, 2014	2014_235507_0017	T-107-14	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA COLOMBO HOMES FOR THE AGED, INC.
40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9

Long-Term Care Home/Foyer de soins de longue durée

VILLA COLOMBO HOMES FOR THE AGED INC.
40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9

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

STELLA NG (507), MATTHEW CHIU (565), NATASHA JONES (591), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 8, 9, 10, 11, 15, 16, 17, 19, 22, 23, 24 and 25, 2014.

**The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI):
T-235-14, T-211-14, T-596-14, 818-14, 975-14, 976-14 and T-585-13.
The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection (RQI):
T-585-14, 966-14, 764-14, 578-14, 624-14, 699-14, 926-14 and 401-14.**

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of resident services (DRS), nursing managers (NMs), registered staff, personal support workers (PSWs), environmental services manager (ESM), interim human resources manager, residents, family members of residents.

During the course of the inspection, the inspector(s) observed residents' care, observed home environment including resident care areas, reviewed residents' records, reviewed the home's records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home and furnishings are maintained in a good state of repair.

Over the course of the inspection, the inspector observed the following examples of home and furnishings not kept in a good state of repair:

- In an identified resident room, the baseboard by the air conditioner was peeling off from the wall.
- In a second identified resident room, a hole in the wall on the left wall, dry wall was damaged below the hole, door frames were damaged
- In a third identified resident room, chipped walls and dented doors.
- In a fourth identified resident room, chipped walls and dented doors. Vanity counter in bathroom was broken with sharp edges, and baseboard over the heater was missing.
- In a fifth identified resident room, chipped walls and dented doors. Vanity counter in bathroom was broken with sharp edges.
- On an identified unit, a hole on the wall by the nursing station.
- Throughout the building, chipped walls and scratch marks on doors.

Interview with the executive director (ED) and the environmental services manager (ESM) confirmed that the above mentioned locations were not maintained in a good state of repair. [s. 15. (2) (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 to ensure that the home and furnishings are maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Record review and interview with the home's director of resident services (DRS) confirmed that the home has had all beds evaluated for zones of entrapment by a contracted company in June 2014, however, has not yet taken measures to prevent resident entrapment considering those identified potential zones of entrapment.

An identified resident's bed system was evaluated for safety and zone 4, the area under the rail, at the end of the rail, was identified as having failed the evaluation for entrapment risk.

A second identified resident's bed system was evaluated for safety and zones 2 and 3, the area under the rail, between the rail supports or next to a single rail support, and the area between the rail and the mattress, were identified as having failed the evaluation for entrapment risk.

A third identified resident's bed system was evaluated for safety and zone 2, the area under the rail, between the rail supports or next to a single rail support, was identified as having failed the evaluation for entrapment risk. The DRS confirmed that the side rails on the bed were tightened on an identified date, but the bed system has not been reassessed to determine whether the identified zone of entrapment was eliminated.

The DRS confirmed that the home is making plans to replace the bed systems which were identified as having potential zones of entrapment. However most of these beds have not yet been replaced, or adjusted to prevent resident entrapment. [s. 15. (1) (b)]

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 where bed rails are used, steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On an identified date, the inspector observed a stack of towels and face cloths on the chair in an identified resident's room. On the same day, the inspector observed a small cart holding various folded sheets, towels, and soaker pads in an identified resident's room. Staff was not present at the time, and a resident was observed enter and then exit the room.

Interview with the PSW assigned to the area revealed that it was common practice for the staff to store the linen cart in the resident's room because when left in the hallway, the ambulatory residents on the unit would remove items, leaving no towels for the staff to provide care.

Interview with an identified personal support worker (PSW) confirmed that he/she was storing towels and face cloths for all his/her assigned residents in the room of one of his/her assigned residents. The PSW confirmed that the linens stored in the identified resident's room were for use with all of his/her assigned residents to prevent another resident from taking them from the linen cart in the hallway and that there is one resident in the area who had behaviour of taking towels from the linen cart, leaving insufficient number for staff to provide care.

During the interview with the identified PSW, the inspector observed the staff member holding the stack of towels against his/her uniform, and observed him/her drop two peri-care wash cloths on the floor, pick them up and add them to the stack of towels.

Interview with an identified registered staff confirmed that staff is expected to bring only linen needed for the resident into the resident's room.

Interview with an identified nurse manager (NM) confirmed that care carts are available on all units, and there is no need for the PSWs to carry the towels against their bodies. Unused towels found in a resident's room cannot be used for another resident. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of an identified resident's Minimum Data Set (MDS) assessments for three months of an identified year, confirmed that the resident was assessed as having impaired vision and as being able to see large, but not regular print in newspapers or books.

Record review and staff interviews confirmed that the identified resident's physician recommended that the resident be encouraged to undergo an annual eye exam. This recommendation was documented in the Doctor's Progress Notes of the resident's most recent four quarterly medication reviews. However, registered staff confirmed that the resident had not had an eye exam offered or arranged since the admission to the unit. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Staff interviews and record review confirmed that care provided for an identified resident was not documented consistently.

Record review of the identified resident's "15 minute monitoring record" for an identified month, revealed that signatures were missing for eleven shifts for the month. Furthermore, monitoring sheets were missing for two days.

Staff interviews confirmed that the PSW and/or the registered staff assigned to the resident was responsible for checking the resident's whereabouts every 15 minutes, and documenting on the monitoring record. The DRS confirmed that this is the home's practice and expectation. [s. 6. (9) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian (RD) 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.

The home's policy titled "Skin and Wound Management", document #16-01-01, revised July 2011, indicates that residents who has stage 2 pressure ulcers are to be referred to the dietitian for recommendations on supplements. This policy is not in accordance with the regulation that states the RD is to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: 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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to promote healing, and prevent infection, as required.

Record review revealed that an identified resident’s skin on the body was red and dark when the resident returned to home from the hospital on an identified date. A lesion on the body was noted the next day, and the bleeding from the body was noted three days later. A stage 2 ulcer on the body was documented on day seven after the resident returned from the hospital. Interventions were not initiated until two days after the stage 2 ulcer was documented.

Interview with the DRS confirmed that immediate treatment and interventions were not provided to the resident to promote wound healing. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review revealed that an identified resident developed a stage 2 ulcer on an identified date, and it was documented as healed six weeks later.

Record review and staff interviews confirmed that skin and wound assessments on the resident’s ulcer were not conducted consistently on a weekly basis. Assessments were not conducted for the last three weeks prior to the healing of the ulcer. [s. 50. (2) (b) (iv)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home.

On an identified date, the inspector observed only one inspection report posted in an unlocked cabinet in the corridor beside the Human Resources office on the ground floor. The following eight inspection reports were not posted:

1. Jan 16/13: 2013-159178-0001
2. May 14/13: 2013-108110-0005
3. May 29/13: 2013-159178-0009
4. Sept 24/13: 2013-159178-0020
5. Jan 7/13: 2013-168202-0069
6. Feb 10/14: 2014-219211-0006
7. Feb 10/14: 2014-219211-0005
8. Feb 25/14: 2014-268529-0005

Interview with the ED confirmed that the above mentioned inspection reports were not posted as required. [s. 79. (3) (k)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;   O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any;   O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and   O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Review of the home's Complaints and Concerns Binder for 2014, revealed that for nine of the 42 written received complaints the documented record did not include all the required information.

Interview with the DRS confirmed that not all of the written complaints logged were completed, and confirmed that verbal complaints are not kept in a documented record.
[s. 101. (2)]

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,**
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that once in every calendar year, the policy to minimize restraints is evaluated to determine the effectiveness of the policy, and identify what changes and improvements are required to minimize restraining and ensure that restraining is done in accordance with the Act and Regulation.

Interview with the NM responsible for the Minimizing of Restraints program confirmed that the home has not conducted an evaluation of the policy to minimize restraints on an annual basis. The identified NM confirmed that an evaluation of the policy was not conducted in 2012 or 2013, and was scheduled to be completed in September 2014, but has not yet been conducted. [s. 113. (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an identified date, the inspector observed the medication cart in the common area of an identified unit unlocked and unattended. There were residents sitting in the common area.

Interview with an identified registered staff confirmed that the medication cart should be locked at all times when unattended. [s. 129. (1) (a)]

2. On another identified date, the inspector observed an unlocked and unattended medication cart on another identified unit. The drawers were open with access to the medication.

Interview with an identified registered staff confirmed that he/she had stepped away from the cart leaving it unlocked and unattended to answer a call bell, and he/she confirmed that the medication cart should be locked at all times when unattended. [s. 129. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive skin and wound care training, as a condition of continuing to have contact with residents.

Record review and interview with the interim human resources manager confirmed that 10 percent of staff who provide direct care to residents did not receive training in skin and wound care management in 2013. [s. 221. (1) 2.]

Issued on this 29th day of September, 2014

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