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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2015	2015_340566_0006	T-1765-15	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

ARIEL JONES (566), JUDITH HART (513), STELLA NG (507), TIINA TRALMAN (162)

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): April 17, 20, 21, 22, 24, 27, 28, 29, and 30, 2015.

The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T-630-13, T-766-14, T-902-14, T-1862-15, T-2349-15.
The following Complaint Intake was inspected concurrently with this Resident Quality Inspection (RQI): T-294-14.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of resident services (DORS), nursing managers (NMs), registered dietitian (RD), interim maintenance manager (IMM), interim human resources manager, food service supervisor (FSS), registered staff, personal support workers (PSWs), dietary aides, housekeeping aides, residents and family members.

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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

11 WN(s)
4 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	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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

An observation on April 17, 2015, revealed that an identified storage room door located on the ground floor was observed to be unlocked.

An interview with an identified nursing manager (NM) confirmed that the door should be locked, and he/she stated that they would follow up. During further observations on April 17, 2015, a maintenance worker was observed fixing the door, and later the inspector found that the storage room door was locked. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: 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 is maintained in a good state of repair.

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

First floor Fidani:
- Scratched drywall, chipped paint on the wall by the dresser and cupboard in room 1138A,
- a hole in the ceiling board in the hallway between rooms 1142 and 1143,
- two holes in the wall outside the conference room,
- scratch marks on the wall behind the nursing station,
- scratch marks on the shower room door, and
- scratch marks on the door to the service elevator.

Second floor Fidani:
- Scratch marks on the door frame of the clean utility room, and
- scratch marks on walls in the shower room and on the shower room door.

Second floor Fusco:
- Dents on the doors to the service elevators, the large dining room and the clean utility room,
- holes in the wall in the common area by the nursing station, and
- a strip was peeled off of the sliding door to the shower cubicle in the shower room.

Third floor Fidani:
- A hole was noted and part of the dry wall was missing from the bottom of the pillar in

the elevator lobby,
- a hole in the wall by the medication room,
- paint was peeled off the wall behind the nursing station,
- a strip of the wooden baseboard facing the entrance of the dining room was missing, and
- scratch marks on doors to the service elevator and shower room.

Third floor Fusco:
- Chipped paint around door frames, damaged wall and chipped paint on the wall beside the bed in room 310A,
- wall damage and chipped drywall on the corner of the wall across from the foot of the bed, a hole in the south wall, wall damage between residents' dressers, and chipped paint on the door frames in room 324B,
- a hole in the wall at ceiling level outside room 305, holes in the wall by the entrance to the large dining room and the wall next to the laundry chute,
- peeled paint by the entrance to room 310, peeled wall paper on the wall facing the nursing station, peeled paint and wall paper on the wall in the common area,
- dented doors to the service elevator and dining room,
- scratch marks on the clean utility room door, and
- missing ceiling light covers at the entrance to rooms 324, 325, 326, and 334; broken ceiling light covers at the entrance to rooms 329 and 334.

An interview with the interim maintenance manager (IMM) confirmed that the above mentioned areas 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 is maintained in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents are protected from abuse by staff.

A review of the progress notes and critical incident report for resident #29 revealed that on an idetnfied date and time in December 2014, an identified dietary aide shouted at the resident while he/she was placing protective covers in the hamper of an identified dining room. The identified dietary aide was heard using profane language toward the resident. A review of the resident's progress notes also revealed that the resident was emotionally disturbed by the incident and was afraid to have meals in the dining room for the next two days.

A review of the home's investigation record and the identified staff member's employment record revealed that an investigation was conducted and the identified staff member was terminated. An interview with an identified NM confirmed that the identified staff member's employment was terminated because of his/her verbally abusive behaviour toward resident #29 on the identified date. [s. 19. (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 all residents are protected from abuse by staff, to be implemented voluntarily.

WN #4: 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 having contact with residents.

Review of the staff education record and interview with the DORS confirmed that 11 percent of staff who provide direct care to residents did not receive training in skin and wound care in 2014. [s. 221. (1) 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 all staff who provide direct care to residents receive skin and wound care training, as a condition of having contact with residents, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others 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.

Interviews with resident #03 revealed that he/she often has difficulty sleeping at night because staff will leave the overhead light on after providing care to his/her roommate. The resident reported that if he/she complains that the light has been left on, the night staff will turn it off.

An interview with an identified PSW who works the day shift revealed that the resident sometimes complains to him/her about the night staff leaving the overhead light on in the resident's room, but that he/she has not passed this information on to the registered staff. He/She stated further that he/she sometimes reminds other PSWs to turn off the light. An interview with an identified member of the registered staff confirmed that he/she was unaware that the resident has difficulty sleeping at night due to the overhead light being left on in his/her room.

A record review of both resident #03 and his/her roommate's written care plans revealed that there was no indication that an overhead light should be left on at night for either resident, or that resident #03 has a preference for the overhead light to be turned off after the provision of care.

An interview with the DORS confirmed that it would be the expectation that staff immediately communicate this type of information to the registered staff on the unit, and that the resident's needs are outlined in his plan of care. [s. 6. (4) (a)]

WN #6: 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 home's Drug Inventory Control policy is complied with.

The home's policy entitled Drug Inventory Control, #02-06-20, revised June 23, 2014, states that: "The following medications will be identified, destroyed and disposed of including: a) expired medications, b) medications with illegible labels... and d) medications that are no longer required due to being discontinued."

On April 22, 2015, the inspector observed the following expired government stock medications in the second floor North/South medication cart:
- Novogesic with an expiry date of January, and an unreadable year,
- Novasen with an expiry date of March, 2015, and
- Allernix with expiry date of January, 2015.

Additionally, resident #31's Naproxen 375mg tablet label stated to discard six months from January 4, 2014.

An interview with the registered staff confirmed that the above medications were expired and should not be on the cart. The identified staff member was then observed to remove the identified expired medications from the cart.

An interview with the DORS confirmed that expired medications should be disposed of according to the home's policy. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

Observations on April 17, 2015, revealed that the call bell system at resident #07's bedside did not ring when engaged at the point of activation when tested by the resident, the inspector or the charge nurse. There was no audible sound or light activated outside of the resident's room, nor was there any indication at the nursing station that the call bell had been activated.

The charge nurse immediately notified maintenance, who replaced the call bell unit. Later that same day, the call bell was observed to work appropriately. [s. 17. (1) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

Record review of the home's investigation notes and staff interviews revealed that on an identified date in April 2015, resident #41 reported to an identified registered staff member that a lady had hit/punched him/her. On this same date, the resident presented with a bruise of unknown origin on an identified area of the body. Interviews with identified registered staff confirmed that they did not immediately notify the weekend on-call Administrator or contact the Director of the Ministry of Health and Long-term Care (MOHLTC), as required.

Record review and interviews revealed that the home initiated an investigation into the above allegations the following day, which they deemed to be inconclusive.

Staff interviews confirmed that the Director (MOHLTC) was notified of the alleged incident of physical abuse by telephone, followed by the submission of critical incident report on the same date that the home's investigation was initiated.

An interview with the DORS confirmed that the home's expectation is to immediately notify the Director (MOHLTC) of any witnessed or suspected abuse. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound care program, including interventions, are documented.

A review of resident #06's physician's order from an identified date in September 2014, indicated the resident's identified ulcer treatment was as follows: cleanse with normal saline, apply hydrogel, cover with measorb and secure with tegaderm every Monday, Wednesday and Friday from an identified date in September to an identified date in November, 2014.

A review of the resident's e-treatment administration record (e-TAR) and interview with an identified registered staff confirmed the dressing changes on Mondays, Wednesdays and Fridays were not documented for the months of September and October 2014.

Review of the home's Skin and Wound Management policy, #16-01-01, revised September 2014, indicates staff members are required to treat residents' ulcers as per physician's orders and document the treatment. An interview with the DORS revealed the dressing changes to resident #06's identified ulcer were expected to have been documented on the e-TAR, and confirmed that this was not completed for the months of September and October 2014. [s. 30. (2)]

WN #10: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident’s admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 at risk of altered skin integrity receives a skin assessment by a member of the registered staff upon any return of the resident from hospital.

A review of resident #06's written plan of care from an identified date in December 2014, revealed that the resident was identified as being at risk for skin breakdown. A review of the resident's health record revealed that the resident was sent to the hospital on a second identified date later in December 2014 and returned to the home two days later with an identified diagnosis.

A review of the resident's health care record revealed that a skin assessment was not completed by a member of the registered staff upon his/her return from the hospital.

Interviews with an identified registered staff and the DORS confirmed that a skin assessment was not completed when resident #06 returned from hospital, as required. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home.

A review of resident #30's progress notes revealed that on an identified date in January 2014, resident #30 was observed to have a bruise on an identified area of one upper extremity. On a second identified date in January 2014, it was noted that the resident had a cut of an identified length over the identified bruise on the identified upper extremity. On a third identified date in January 2014, the resident's was observed to be bleeding from the dressing site. On a fourth identified date in January 2014, an open area of specified dimensions was observed on the same site and identified as a skin tear.

Record review failed to confirm that an assessment had been completed by the registered dietitian (RD), or that a referral had been sent to the RD for the resident's skin tear and altered skin integrity.

Interviews with an identified registered staff and the RD confirmed that an RD assessment had not been completed for the skin tear, as required. [s. 50. (2) (b) (iii)]

WN #11: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the home's infection prevention and control (IPAC) program and an interview with the IPAC lead confirmed that the IPAC program was not evaluated in 2014. [s. 229. (2) (d)]

Issued on this 21st day of May, 2015

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

Original report signed by the inspector.