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

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

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Inspection de soins de longue durée

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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
Jun 9, 2016	2016_398605_0014	010399-16	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

SARAH KENNEDY (605), ARIEL JONES (566), JUDITH HART (513), NATALIE MOLIN (652), 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): April 14, 15, 18, 19, 20, 21, 22, 25, 27, 28, 29 and May 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 2016.

The following critical incident (CI) inspections were conducted concurrently with the RQI: 002191-14, 015729-15, 005058-15, 005231-16, 021486-15, 027452-15, 024758 -15, 034465-15, 009212-16, 011345-16, 023745-15, 023914-15, 008909-14, 030327-15, 030367-15, 026097-15, 006670-15, 003739-15, 016870-15, 007995-16, 011860-16, 014714-16.

The following complaint inspections were conducted concurrently with the RQI: 008323-16, 010882-15, 016015-15, 020534-15, 009082-14, 003730-14, 000390-15, 004810-15, 030263-15, 005722-16, 026326-15, 016519-15, 011507-15, 009944-15.

During the course of the inspection, the inspector(s) spoke with the director of resident services (DRS), nursing directors, registered staff, food service supervisor (FSS), registered dietitians (RDs), physiotherapists (PT), physiotherapist assistant, social workers, personal support workers (PSWs), restorative care coordinator, dietary aide, resident services scheduling coordinator, laundry aides, housekeeping manager, housekeepers, maintenance manager, residents, substitute decision makers (SDMs), Residents' Council president and Family Council president.

During the course of the inspection, the inspector(s) conducted a tour of the home and observed meal service, medication administration, staff to resident interactions and the provision of care, and reviewed health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **4 VPC(s)**
- **2 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 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 residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, and "financial abuse" means any misappropriation or misuse of a resident's money or property.

A record review of a Critical Incident Report (CIR), revealed that on an identified date, resident #053 reported to staff that he/she had given PSW #108 an identified item and now wanted the item back, but the PSW had not returned the item and was now not talking to him/her. The CIR revealed that in following up on the resident's concerns, the home found that the identified PSW had been offered and accepted personal items from resident #053 over an extended period of time.

An interview with resident #053 revealed that he/she had been giving his/her own personal items to PSW #108 as gifts over the course of at least a year, and that this PSW would accept these items. He/she stated that the PSW would run errands for him/her, with money provided by the resident, and that PSW #108 would not always return his/her change. The resident confirmed that he/she felt as if he/she had developed a friendship with PSW #108 and stated further that PSW #108 would talk to him/her about his/her personal life. Resident #053 stated that their relationship had changed when PSW #108 asked him/her to return an item. The resident reportedly returned all of the items that PSW #108 had given him/her and then requested that the PSW return the identified item that the resident had given to him/her. PSW #108 did not return the item.

An interview with PSW #108 revealed that resident #053 offered him/her items, over an extended period of time, which he/she would take because he/she did not want to offend the resident. He/she stated that he/she never asked the resident for specific items and never stole from the resident, but that resident #053 would offer him/her items that the resident no longer wanted. PSW #108 stated that he/she did not consider these items to be gifts as they were old things and were not specifically purchased for him/her. PSW #108 confirmed that he/she would buy items for the resident at the resident's request, but stated that he/she always returned the resident's change with a receipt. He/she also confirmed that he/she had loaned an identified personal care item to the resident, and when he/she realized the resident was no longer using them, he/she requested them returned. PSW #108 revealed the resident then asked for a specific item back, however, he/she no longer had it, so he/she was unable to return it. PSW #108 confirmed that he/she felt like it was inappropriate to take items from resident #053 and that their

therapeutic relationship changed to one with an imbalance of power which ultimately caused a problem. The PSW admitted that he/she should not have accepted gifts from or spoken to the resident in a manner that crossed over that line.

Further record review of the home’s investigation notes into the incident revealed that the home conducted an investigation and concluded that staff to resident emotional and financial abuse had occurred by PSW #108 toward resident #053. As a result of the home’s investigation, PSW #108's employment was terminated.

An interview with nursing director #100 confirmed that this incident was immediately investigated and that PSW #108 was terminated as a result. He/she confirmed further that the home failed to protect resident #053 from abuse by PSW #108. [s. 19. (1)]

2. For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A review of a CIR revealed on an identified date, at 0420hrs a verbal altercation was heard between resident #042 and resident #045. When staff responded, resident #042 was observed standing beside resident #045 who was lying on the washroom floor. Resident #045 claimed that he/she was hit on an identified area of the body by resident #042. Resident #045 sustained an injury. Resident #045 complained of pain to the injured area, was sent to hospital for assessment and diagnostic test results were normal. Review of the progress notes for residents #042 and #045 confirmed the above details.

A review of resident #042 and #045's written care plans, Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments and progress notes indicated that both residents were cognitively impaired and resident #042 had a history of exhibiting verbal and physical aggression towards other residents. Review of the above documents revealed resident #045 also had a history of exhibiting verbal and physical aggression to staff and residents.

An interview with RPN #156 revealed resident #042 and resident #045 had a physical altercation in which resident #045 sustained an injury.

An interview with the Director of Resident Services (DRS) confirmed resident #042 and resident #045 had an altercation in which resident #045 was injured and confirmed this

constitutes resident to resident abuse. [s. 19. (1)]

3. A review of a CIR revealed that on an identified date, at 2330hrs, PSW #152 heard screaming coming from resident #041's room. Upon entering the room, the PSW found resident #041 hitting co-resident #044 with an identified item. As a result, resident #044 sustained an injury.

A review of the progress notes for residents #041 and #044 confirmed that the residents had an altercation on April 27, 2014, and that resident #044 sustained an injury.

A review of resident #041 and resident #044's written care plans, RAI-MDS assessments and progress notes indicated that both residents were severely cognitively impaired.

Interviews with PSW #152, RPN #143 and RPN #184 confirmed that resident #041 was found hitting resident #044 with an identified item and caused an injury to resident #044.

An interview with the DRS confirmed that resident #041 hit resident #044 with an identified item, causing injury. [s. 19. (1)]

4. A review of a CIR revealed that on an identified date, resident #057 grabbed resident #058 and tried to press his/her down onto the floor. A review of resident #057 and #058's written care plans, RAI-MDS assessments and progress notes indicated both residents were cognitively impaired and had a history of wandering behaviours and verbal/physical aggression.

A review of the incident notes revealed that residents #057 and #058 got into a physical altercation on the night shift of an identified date. While both residents were wandering in the corridors, resident #057 asked resident #058 a question that he/she could not answer. Resident #057 then grabbed resident #058 and forced him/her down toward the floor. Two staff members immediately intervened and separated both residents. Nursing assessment revealed that resident #058 sustained injury.

Interviews with PSW #116 and RPN #170 revealed that resident #057 is cognitively impaired, has behaviours and can be physically aggressive with co-residents. PSW #116 observed this altercation, intervened and separated the residents. RPN #170 confirmed that resident #058 sustained injury following the incident.

An interview with nursing director #100 confirmed that the police were notified following

the incident and no charges were laid. It was also confirmed that by the nature of the incident and the injury sustained, resident #058 was not protected from abuse by resident #057. [s. 19. (1)]

5. A review of a CIR, revealed resident #026 was hit by resident #029 on an identified date. As a result, resident #026 sustained an injury, and was sent to hospital. The police were notified.

A review of the progress notes for residents #026 and #029 confirmed that the residents had an altercation on an identified date, causing injury to resident #026. The incident was not witnessed.

A review of resident #029's written care plan revealed he experiences physical aggression related to dementia/cognitive impairment.

An interview with resident #026 confirmed that on the identified date, resident #026 was sitting in the activity room watching TV when resident #029 came up from behind and hit him/her with an identified item.

An interview with nursing director #111 confirmed resident #026 was hit by resident #029 and sustained an injury.

The home failed to protect residents #053, #045, #044, #058 and #026 from abuse by anyone.

The scope of this non-compliance is isolated as it relates to five residents. The severity is actual harm/risk. The home's Compliance History Report reveals a VPC was issued on April 6, 2016. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)]

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 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, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Areas of disrepair were observed within resident rooms in eight out of the nine resident home areas. Observations made during the RQI revealed the following areas of disrepair in resident rooms:

1 Fidani:
1137 resident washroom: paint missing and drywall damaged along the top of the baseboards
1141-A: drywall damaged in bedroom and baseboard missing in bathroom

2 Fidani:
2249-A: drywall above baseboards in resident's washroom is exposed
2248 resident washroom: paint missing and drywall damaged along the top of the baseboards
2259: paint peeling and drywall damaged

2 Fusco:
221 resident washroom: laminate on inside of the bathroom door is broken, leaving a jagged edge
218-B: baseboards lifting from the wall around resident's bed space and in corner of room
201 resident washroom: laminate on inside of the bathroom door is broken

3 Fidani:

3348: numerous areas of paint and drywall damage within the room
3361-A: missing baseboard within room
3353 resident washroom: floor is damaged under sink and in middle of washroom, creating a potential tripping hazard

3 Fusco:
308-A: baseboards missing under sink in washroom, wall damage beside resident's bed

4 Fidani:
4453: paint and drywall damage in numerous areas throughout the room

4 Fusco:
419-A: strip of unpainted drywall running along entire wall at mid-level

5 Fidani:
5540-A: paint and drywall damage at foot of bed
5538-A: paint and drywall damage within room, laminate on bathroom counter is peeling off

The inspector toured these areas with the home's Maintenance Manager on May 4, 2016, at which time he confirmed that all of the above areas require repair. The Maintenance Manager stated that these areas would be repaired, beginning with the washroom in room 3353, as it could put residents at risk. He stated that all of the above areas of disrepair would be remedied within 90 days. [s. 15. (2) (c)]

2. On May 16, 2016, the following areas of disrepair were observed in resident room 431 bedroom and washroom:

- three walls within the room require drywall patching and painting
- the corner of bed B's end table is broken, leaving rough, unfinished wood
- base of the toilet is cracked
- sink is chipped on the edge, and rusty where it meets the counter top
- edging of counter is broken and jagged below sink
- orange discolouration on the washroom floor where the base of the wall meets the floor beside the toilet, grout appears to be missing between the floor and the base of the wall

On May 17, 2016, the inspector observed these areas of disrepair with the home's Maintenance Manager. The Maintenance Manager agreed that these areas were in need

of repair or replacement.

The scope of this non-compliance is widespread as areas of disrepair were observed in eight out of nine resident home areas. The severity is minimum risk. The homes Compliance History Report reveals a VPC was issued on May 6, 2015. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to resident #047 and #007.

A complaint involving resident #047, related to responsive behaviours was inspected concurrently with the RQI. Interviews with RPN #159, RPN #168, PSW #164, PSW #158 and PSW #161 all revealed that resident #047 exhibits an identified responsive behaviour. This behaviour was reportedly worse in the past.

A review of the resident's RAI-MDS assessments confirmed that the resident had been assessed to have socially inappropriate or disruptive behaviours.

A review of the resident's progress notes revealed frequent notes referring to the resident exhibiting the behaviour, sometimes during the night.

A review of the resident's plan of care revealed no written plan of care to manage the resident's behaviour.

Interviews with RPN #159 and PSW #164 confirmed that although the staff had strategies that they use to address the resident's behaviour, no written plan of care was in place documenting these interventions to manage the behaviour.

An interview with the home's DRS confirmed that a written plan of care should have been completed detailing the resident's behaviour and the interventions and goals they were trying to achieve. The DRS confirmed that no written plan of care had been developed to address the resident's behaviour. [s. 6. (1)]

2. On an identified date, an observation of resident #007 revealed two areas of the body covered with dressing.

A review of the resident’s current written care plan, revealed the resident was at high risk for poor skin integrity.

A progress note revealed the resident sustained impaired skin integrity from an unknown cause, and on an identified date, sustained impaired skin integrity, during the resident’s bath. Both areas were cleansed and a protective dressing was applied.

A review of the medication administration record (MAR) and treatment administration record (TAR) revealed no treatment protocols for dressing changes.

An interview with RPN #137 confirmed resident #007's written plan of care did not include care of impaired skin integrity. An interview with the DRS confirmed the plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (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 there was a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: 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 failed to ensure that any policy put in place was complied with.

A complaint related to inadequate fluid intake was inspected concurrently with the RQI. A review of the resident care policy for "Food and Fluid Intake Monitoring", reference number RESI-05-02-05, version May 2014, revealed if a resident consumes less than their minimum fluid target levels for three consecutive days, the resident requires a hydration assessment. The hydration assessment must be documented and a referral should be sent to the registered dietitian/designate for additional assessment and strategies.

A review of resident #036's progress notes revealed the resident was living with medical conditions affecting appetite and intake. The resident was admitted to hospital on an identified date, with a medical diagnosis and received treatment. The resident was subsequently hospitalized for other medical conditions.

A review of the pertinent monthly food and fluid intake record revealed resident #036's fluid intake was declining over the course of a month from the established goal of 10-11 cups. Every day over a 22 day period, resident #036's fluid intake was below the established daily goal.

Interviews with RPN #143 and the DRS confirmed that on the identified dates, the resident did not meet the established daily fluid goal, a hydration assessment had not been completed, and a referral was not sent to the RD, therefore not complying with the fluid intake monitoring policy. [s. 8. (1) (a),s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there are schedules and procedures in place for routine, preventive and remedial maintenance of walls and floors.

Observations made during the RQI revealed areas of disrepair in 17 resident rooms located on eight out of nine resident care areas in the home. The disrepair included damaged drywall, chipped and peeling paint, damaged laminate on bathroom doors and damaged flooring in one resident washroom (see finding s. 15. (2) (c) for a detailed description of the areas in disrepair).

During a tour of the affected rooms on May 4, 2016, the home's Maintenance Manager confirmed that all of the areas required repair. The Maintenance Manager revealed that the home's system for maintaining floors and walls within resident rooms consists of:

1) repairing and painting the room when one resident vacates, before the next resident is admitted and,
2) making repairs to rooms when he is informed by families, residents or staff that a repair is needed.

The Maintenance Manager confirmed that no staff or family had informed him of the above 17 rooms which required repair, and no system was in place to audit the resident rooms for disrepair.

The Maintenance Manager confirmed the home's current maintenance process is not working to keep resident rooms in a state of good repair. [s. 90. (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 as part of the organized program of maintenance services, there are schedules and procedures in place for routine, preventive and remedial maintenance of walls and floors, to be implemented voluntarily.

WN #6: 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).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

On an identified date, observations during medication administration on an identified resident area revealed RPN #131 did not consistently perform hand hygiene before and after resident contact. During the medication administration for 15 residents, the inspector observed RPN #131 perform hand hygiene twice.

An interview with RPN #131 confirmed that she did not perform hand hygiene before and after each contact with residents. RPN #131 stated the hand hygiene product irritated her hands.

An interview with the DRS confirmed that the expectation is for staff to perform hand

hygiene, before and after resident contact, when administering medications. RPN #131 did not participate in the implementation of the IPAC program. [s. 229. (4)]

2. On three identified dates, the inspector observed in an identified residents' washroom, a white plastic measuring container sitting inside a pink washbasin. Both items were unlabelled, and had been placed on top of a stool under the washroom sink.

Interviews with PSW #161 and RPN #159 revealed that the white measuring container is used to drain and measure urine before discarding it. An interview with PSW #164 revealed that the pink basin is used to wash residents.

An interview and observation of the room with the home's IPAC Coordinator, confirmed that the measuring container and basin in the room were being stored improperly. The white measuring container should be stored in the resident's cupboard in the washroom, and the basin should be stored at the resident's bedside. He/she confirmed that because the measuring container is used to empty urine it should not be stored inside of the resident's basin, as the resident will be washed from that basin. She also confirmed that both items should be labelled. [s. 229. (4)]

3. The licensee has failed to ensure that there is a hand-hygiene program with access to point-of-care hand hygiene agents.

Observations in the home during the RQI revealed that in a number of resident rooms on various units, hand hygiene agents were not accessible at the point-of-care. The inspector, accompanied by the home's IPAC lead, toured the second, third, and fourth floors and observed hand sanitizer units were not available within 13 resident rooms. The inspector toured the fifth floor independently and observed no hand sanitizers were available in five additional resident rooms.The inspector and IPAC lead also observed that in all the rooms on the North and South wings of 4 Fusco, the hand sanitizers had been installed behind the privacy curtain, which the IPAC lead stated was incorrect placement, as they would not be visible to staff, and would be inaccessible to staff unless they moved the curtain to reach them.

An interview with PSW #158 revealed that staff use the wall mounted hand sanitizers for hand hygiene when providing care to residents within their rooms.

The home's IPAC lead confirmed that hand sanitizer should be available at point-of-care in every resident room, and outside every doorway. [s. 229. (9)]

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 participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: 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 the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm immediately report the suspicion and the information upon which it was based to the Director.

A review of a CIR, revealed an alleged staff to resident abuse took place on an identified date. The home submitted the CIR to the Director eight days following the incident.

An interview with nursing director #118 confirmed the Director was not immediately notified of the alleged abuse. [s. 24. (1)]

WN #8: 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 tears, has been assessed by a registered dietitian who is a member of the staff of the home.

On an identified date, an observation of resident #007 revealed two areas of the body covered with dressings.

A review of resident #007's current written care plan identified this resident was at high risk for poor skin integrity.

A review of the progress notes revealed the resident sustained impaired skin integrity from an unknown cause, and sustained impaired skin integrity, during the resident's bath. Both areas were cleansed and a protective dressing was applied. A further review of the progress notes and resident records did not identify that a referral to the registered dietitian had been made.

An interview with RPN #137 and RD #136 confirmed a consult to the registered dietitian was not initiated.The DRS confirmed that a dietary consult had not been sent. [s. 50. (2) (b) (iii)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of resident 033's physician's orders revealed an identified medication was prescribed to be administered by mouth at bedtime.

A review of the MAR for an identified date, at bedtime (2200hrs), revealed RPN #151 recorded the identified medication was signed off as administered at 1950hrs.

A review of the Medication Incident Report for an identified date, revealed the documentation of a missed dose of the medication. An interview with RPN #151 confirmed that the medication had not been administered to resident #033 as prescribed.

An interview with the DRS confirmed that RPN #151 did not administer the medication as prescribed and disciplinary action had been taken. [s. 131. (2)]

Issued on this 21st day of June, 2016

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

Original report signed by the inspector.

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

Ministére 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

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) :	SARAH KENNEDY (605), ARIEL JONES (566), JUDITH HART (513), NATALIE MOLIN (652), SUSAN LUI (178)
Inspection No. / No de l'inspection :	2016_398605_0014
Log No. / Registre no:	010399-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 9, 2016
Licensee / Titulaire de permis :	VILLA COLOMBO HOMES FOR THE AGED, INC. 40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9
LTC Home / Foyer de SLD :	VILLA COLOMBO HOMES FOR THE AGED INC. 40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracey Comeau

To VILLA COLOMBO HOMES FOR THE AGED, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse by anyone. The plan shall include the development and implementation of a system of ongoing monitoring to:

1) Prevent resident to resident abuse, and
2) ensure staff are complying with the home's policy and procedures related to zero tolerance of abuse and neglect.

This plan is to be submitted via email to inspector sarah.kennedy@ontario.ca by July 7, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, and "financial abuse" means any misappropriation or misuse of a resident's money or property.

A record review of a Critical Incident Report (CIR), revealed that on an identified date, resident #053 reported to staff that he/she had given PSW #108 an identified item and now wanted the item back, but the PSW had not returned the item and was now not talking to him/her. The CIR revealed that in following up on the resident's concerns, the home found that the identified PSW had been

offered and accepted personal items from resident #053 over an extended period of time.

An interview with resident #053 revealed that he/she had been giving his/her own personal items to PSW #108 as gifts over the course of at least a year, and that this PSW would accept these items. He/she stated that the PSW would run errands for him/her, with money provided by the resident, and that PSW #108 would not always return his/her change. The resident confirmed that he/she felt as if he/she had developed a friendship with PSW #108 and stated further that PSW #108 would talk to him/her about his/her personal life. Resident #053 stated that their relationship had changed when PSW #108 asked him/her to return an item. The resident reportedly returned all of the items that PSW #108 had given him/her and then requested that the PSW return the identified item that the resident had given to him/her. PSW #108 did not return the item.

An interview with PSW #108 revealed that resident #053 offered him/her items, over an extended period of time, which he/she would take because he/she did not want to offend the resident. He/she stated that he/she never asked the resident for specific items and never stole from the resident, but that resident #053 would offer him/her items that the resident no longer wanted. PSW #108 stated that he/she did not consider these items to be gifts as they were old things and were not specifically purchased for him/her. PSW #108 confirmed that he/she would buy items for the resident at the resident's request, but stated that he/she always returned the resident's change with a receipt. He/she also confirmed that he/she had loaned an identified personal care item to the resident, and when he/she realized the resident was no longer using them, he/she requested them returned. PSW #108 revealed the resident then asked for a specific item back, however, he/she no longer had it, so he/she was unable to return it. PSW #108 confirmed that he/she felt like it was inappropriate to take items from resident #053 and that their therapeutic relationship changed to one with an imbalance of power which ultimately caused a problem. The PSW admitted that he/she should not have accepted gifts from or spoken to the resident in a manner that crossed over that line.

Further record review of the home's investigation notes into the incident revealed that the home conducted an investigation and concluded that staff to resident emotional and financial abuse had occurred by PSW #108 toward resident #053. As a result of the home's investigation, PSW #108's employment was terminated.

An interview with nursing director #100 confirmed that this incident was immediately investigated and that PSW #108 was terminated as a result. He/she confirmed further that the home failed to protect resident #053 from abuse by PSW #108. [s. 19. (1)]

2. For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A review of a CIR revealed on an identified date, at 0420hrs a verbal altercation was heard between resident #042 and resident #045. When staff responded, resident #042 was observed standing beside resident #045 who was lying on the washroom floor. Resident #045 claimed that he/she was hit on an identified area of the body by resident #042. Resident #045 sustained an injury. Resident #045 complained of pain to the injured area, was sent to hospital for assessment and diagnostic test results were normal. Review of the progress notes for residents #042 and #045 confirmed the above details.

A review of resident #042 and #045's written care plans, Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments and progress notes indicated that both residents were cognitively impaired and resident #042 had a history of exhibiting verbal and physical aggression towards other residents. Review of the above documents revealed resident #045 also had a history of exhibiting verbal and physical aggression to staff and residents.

An interview with RPN #156 revealed resident #042 and resident #045 had a physical altercation in which resident #045 sustained an injury.

An interview with the Director of Resident Services (DRS) confirmed resident #042 and resident #045 had an altercation in which resident #045 was injured and confirmed this constitutes resident to resident abuse. [s. 19. (1)]

3. A review of a CIR revealed that on an identified date, at 2330hrs, PSW #152 heard screaming coming from resident #041's room. Upon entering the room, the PSW found resident #041 hitting co-resident #044 with an identified item. As a result, resident #044 sustained an injury.

A review of the progress notes for residents #041 and #044 confirmed that the

residents had an altercation on April 27, 2014, and that resident #044 sustained an injury.

A review of resident #041 and resident #044's written care plans, RAI-MDS assessments and progress notes indicated that both residents were severely cognitively impaired.

Interviews with PSW #152, RPN #143 and RPN #184 confirmed that resident #041 was found hitting resident #044 with an identified item and caused an injury to resident #044.

An interview with the DRS confirmed that resident #041 hit resident #044 with an identified item, causing injury. [s. 19. (1)]

4. A review of a CIR revealed that on an identified date, resident #057 grabbed resident #058 and tried to press his/her down onto the floor. A review of resident #057 and #058's written care plans, RAI-MDS assessments and progress notes indicated both residents were cognitively impaired and had a history of wandering behaviours and verbal/physical aggression.

A review of the incident notes revealed that residents #057 and #058 got into a physical altercation on the night shift of an identified date. While both residents were wandering in the corridors, resident #057 asked resident #058 a question that he/she could not answer. Resident #057 then grabbed resident #058 and forced him/her down toward the floor. Two staff members immediately intervened and separated both residents. Nursing assessment revealed that resident #058 sustained injury.

Interviews with PSW #116 and RPN #170 revealed that resident #057 is cognitively impaired, has behaviours and can be physically aggressive with co-residents. PSW #116 observed this altercation, intervened and separated the residents. RPN #170 confirmed that resident #058 sustained injury following the incident.

An interview with nursing director #100 confirmed that the police were notified following the incident and no charges were laid. It was also confirmed that by the nature of the incident and the injury sustained, resident #058 was not protected from abuse by resident #057. [s. 19. (1)]

5. A review of a CIR, revealed resident #026 was hit by resident #029 on an identified date. As a result, resident #026 sustained an injury, and was sent to hospital. The police were notified.

A review of the progress notes for residents #026 and #029 confirmed that the residents had an altercation on an identified date, causing injury to resident #026. The incident was not witnessed.

A review of resident #029's written care plan revealed he experiences physical aggression related to dementia/cognitive impairment.

An interview with resident #026 confirmed that on the identified date, resident #026 was sitting in the activity room watching TV when resident #029 came up from behind and hit him/her with an identified item.

An interview with nursing director #111 confirmed resident #026 was hit by resident #029 and sustained an injury.

The home failed to protect residents #053, #045, #044, #058 and #026 from abuse by anyone.

The scope of this non-compliance is isolated as it relates to five residents. The severity is actual harm/risk. The home's Compliance History Report reveals a VPC was issued on April 6, 2016. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)] (566)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident rooms are maintained in a good state of repair. This includes but is not limited to the areas listed below.

The plan shall be submitted via email to sarah.kennedy@ontario.ca by July 7, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Areas of disrepair were observed within resident rooms in eight out of the nine resident home areas. Observations made during the RQI revealed the following areas of disrepair in resident rooms:

1 Fidani:
1137 resident washroom: paint missing and drywall damaged along the top of the baseboards
1141-A: drywall damaged in bedroom and baseboard missing in bathroom

2 Fidani:
2249-A: drywall above baseboards in resident's washroom is exposed
2248 resident washroom: paint missing and drywall damaged along the top of

the baseboards
2259: paint peeling and drywall damaged

2 Fusco:
221 resident washroom: laminate on inside of the bathroom door is broken, leaving a jagged edge
218-B: baseboards lifting from the wall around resident's bed space and in corner of room
201 resident washroom: laminate on inside of the bathroom door is broken

3 Fidani:
3348: numerous areas of paint and drywall damage within the room
3361-A: missing baseboard within room
3353 resident washroom: floor is damaged under sink and in middle of washroom, creating a potential tripping hazard

3 Fusco:
308-A: baseboards missing under sink in washroom, wall damage beside resident's bed

4 Fidani:
4453: paint and drywall damage in numerous areas throughout the room

4 Fusco:
419-A: strip of unpainted drywall running along entire wall at mid-level

5 Fidani:
5540-A: paint and drywall damage at foot of bed
5538-A: paint and drywall damage within room, laminate on bathroom counter is peeling off

The inspector toured these areas with the home's Maintenance Manager on May 4, 2016, at which time he confirmed that all of the above areas require repair. The Maintenance Manager stated that these areas would be repaired, beginning with the washroom in room 3353, as it could put residents at risk. He stated that all of the above areas of disrepair would be remedied within 90 days.

2. On May 16, 2016, the following areas of disrepair were observed in resident room 431 bedroom and washroom:

- three walls within the room require drywall patching and painting
- the corner of bed B's end table is broken, leaving rough, unfinished wood
- base of the toilet is cracked
- sink is chipped on the edge, and rusty where it meets the counter top
- edging of counter is broken and jagged below sink
- orange discolouration on the washroom floor where the base of the wall meets the floor beside the toilet, grout appears to be missing between the floor and the base of the wall

On May 17, 2016, the inspector observed these areas of disrepair with the home's Maintenance Manager. The Maintenance Manager agreed that these areas were in need of repair or replacement.

The scope of this non-compliance is widespread as areas of disrepair were observed in eight out of nine resident home areas. The severity is minimum risk. The homes Compliance History Report reveals a VPC was issued on May 6, 2015. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2016

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Kennedy

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