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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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 31, 2017	2017_642606_0006	016656-16, 020561-16, 027681-16, 006096-17	Complaint

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

JANET GROUX (606), JULIEANN HING (649), NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 30, 31, April 3, 4, 5, 6, 7, 10, 11, 12, 13, 18, 19, 20, 21, 24, 25, 26, 27, 28, May 1, 2, 4, 5, 8, 9, 10, 2017.

Complaints- Log #: 016656-16 related t the Resident's Bill of Rights, Plan of Care, Continence Care and Bowel Management, 020561-16 related to Housekeeping, Duty to Protect, and Personal Care, 027681-16 related to Responsive Behaviours, Emergency Plans, Plan of Care, and Prevention of Abuse and Neglect, and 006096-17 related to transferring and positioning, medication management, and falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Executive Director (A)ED, Director of Resident Services (DRS), Director of Nursing: Units One, Two, Three, Four, and Fifth Floor, Social Workers (SW), Doctors, Physiotherapists (PT), Physiotherapist Assistants (PTAs), Maintenance Worker (MW), Housekeeping, Dietary Aides (DA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Makers (SDMs), and Residents.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 1. That staff only applied the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Record review of a complaint reported to the Ministry of Health and Long Term Care (MOHLTC) alleged resident #003 fell out of bed on an identified date and time after he/she was transferred from one unit to another because staff did not apply the correct identified device when the resident was in bed.

Record review of resident #003's plan of care revealed he/she was diagnosed with an identified medical condition and was high risk for falls and injury. Further review of the resident's plan of care indicated resident #003 required to have an identified device when resident was in bed and was requested by the SDM.

Record review of the doctor's order on an identified indicated that staff are to to apply the identified device when the resident was in bed as per SDM's decision.

Record review of resident #003's clinical records on an identified date and time indicated resident #003 was transferred from an identified room and unit to another. Further review revealed at an identified time resident #003 was found by RPN #114 on the floor in an identified position. On assessment the RPN stated the resident sustained no injury from the fall and indicated resident #003 was not able to express what caused him/her to fall to the floor.

Interview with RPN #114 indicated resident was transferred on an identified date and time from an identified unit to another and stated the resident required an identified device when he/she is in bed. The RPN stated he/she observed that the identified device were not the device as ordered by the doctor and that the identified device would have helped the resident from falling.

Interview with PSW # 141 stated he/she was one of the staff who responded when resident #003 had the fall. He/she stated resident was in an identified state that on an identified time he/she and another staff member put the resident back to bed after the resident was finished an identified meal service and confirmed they applied the identified device. PSW #141 stated resident #003 may have fallen because the identified device were not the correct type and that the device had been applied correctly.

Interview with Maintenance Worker # 161 indicated the maintenance department is notified by the nursing staff whenever any device is to be applied.

Interview with the Director of Nursing #143 indicated that when a resident is transferred from one unit to another unit, the registered staff are responsible to notify the maintenance department to transfer any devices as ordered by the doctor and indicated this was not done. He/she stated resident #003 did not have the correct devices when he/she was transferred to the identified unit. [s. 110. (2) 1.]

2. The licensee has failed to ensure that that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 2. That staff applied the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Record review of a complaint reported to the MOHLTC alleged resident #003 slid out of his/her mobility aide because staff did not place resident #003's mobility aide in an identified position and apply his/her identified device before walking away.

Record review of resident #003 ‘s plan of care revealed he/she was diagnosed with a medical condition and was high risk for injury/falls. Further review of the resident’s plan of care indicated resident #003 required an identified device when up in the identified mobility aide and was requested by the SDM.

Record review of the doctor's order dated on an identified date, indicated for staff to apply the identified device when the resident was in the identified mobility aide as per SDM's decision.

Record review of resident's clinical records on an identified date and time indicated resident #003 slid off his/her identified mobility aide because the identified device was not applied.

Interview with PSW #187 stated resident #003 was exhibiting responsive behaviours during an identified date and time. The PSW indicated the resident's SDM told him/her to leave resident #003 in his/her care. PSW #003 stated he/she did not apply the identified device on the mobility aide before he/she left resident #003 with his/her SDM.

Interview with RPN #191 stated it was his/her first day to work on the unit and was aware that resident #003‘s plan of care directed staff to apply his/her identified device when the resident was up in his/her mobility aide due to his/her risk of falling. The RPN stated he/she was nearby where resident #003 was located and when he/she looked up and saw the on the floor beside his/her mobility aide. RPN #191 revealed he/she responded and assessed the resident and indicated there were no injuries noted.

Interview with the DRS stated it was the staff's responsibility to provide the care to resident #003 and not rely on the SDM and stated PSW #187 should have applied the identified device on the resident before leaving him/her with the SDM.

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 following requirements are met where a resident was being restrained by a physical device under section 31 of the Act: 1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class;
-to ensure that that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

Review of a complaint was submitted to the MOHLTC and alleged that staff did not respond immediately and appropriately when resident #043 had a change in his/her condition.

Record review on an identified date and time indicated resident #043 was in a physiotherapy program being assisted by the PT and two PTAs when the resident had a change in his/her condition and was immediately seated back into his/her mobility aide. Further review indicated an identified emergency procedure was performed by the doctor and the resident was subsequently transferred to the hospital.

Interviews with PT #010, PTA #045 and #048, RPN #002, and RN #054 revealed that they had not received or attended any training on medical emergency since being employed by the home.

The inspector requested written documentation of the home's training records related to medical emergency plans.

Interview with the DRS revealed the home did not have any training records related to medical emergency planning.

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 a written record is kept of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) received training in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Review of a complaint was submitted to the MOHLTC and alleged that staff did not respond immediately and appropriately when resident #043 had a change in his/her condition.

Interviews with PT#010, PTA #045 and #048, RPN #002, and RN #054 revealed that they had not received or attended any training on medical emergency since being employed by the home. The staff's employment range varied with the most recent being less than three years.

Interview with the DRS revealed the home had not provided training to staff working at the home on medical emergency at intervals provided for in the regulation. [s. 76. (4)]

Issued on this 30th day of June, 2017

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

Original report signed by the inspector.