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
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5700 rue Yonge 5e étage
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2017	2017_378116_0015	019215-17, 019219-17, 019220-17, 019222-17	Follow up

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 18, 19, 20, 23, 24, 25, 2017.

This inspection was conducted concurrently with the 2017 resident quality inspection (RQI) for the purposes of following up on previously served orders under the following areas within the Act and regulations:
Order #001- LTCHA, 2007 S.O. 2007, c.8, s.19. (1)
Order #002- O.Reg. 79/10, s. 36
Order #003- LTCHA, 2007 S.O. 2007, c.8, s. 6(10)
Order #004- LTCHA, 2007, c.8. s. 15(2) c.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Assistant Executive Director, Director of Care (DOC), a Director of Nursing, manager of housekeeping, laundry and maintenance lead, maintenance staff members, registered staff (RN) (RPN), personal support worker's (PSW) and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2017_642606_0007	116
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_642606_0005	116
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #003	2017_642606_0005	116

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A previous compliance order was served under inspection report #2017_642606_0005, related to staff use of safe transferring and positioning techniques when assisting

residents. Compliance order #002 under inspection report #2017_642606_0005 directed the licensee to prepare, submit and implement a plan to achieve compliance in the area of safe transferring and positioning techniques.
The licensee was ordered to ensure that all staff in the home receive hands on training to demonstrate that staff use safe transferring and positioning techniques when assisting residents. The plan shall also include a system to audit and evaluate the training program. The home was ordered to be in compliance by a specified date.

An interview held with the DOC indicated that the home employs an identified number of direct care staff members that would require hands on training on safe transferring and positioning techniques.

Review of the home's education records for training on safe transferring and positioning techniques and training of the lift and transfer policy on an identified date, revealed that not all direct care staff members received the hands on training on safe transferring techniques.

In an interview, the nursing director of an identified unit stated that hands on training was only provided to an identified number of specified staff members.
In an interview with the DOC it was indicated that the hands on training was to be provided to direct care staff members in three forms, by an external educator, by review of the licensee's lift and transfer policy, and in addition; in-person training provided by specified staff members who were trained to provide additional hands-on in-person sessions to pertinent staff members.

Review of the educational records on safe transferring and positioning techniques and further interview with the DOC acknowledged that the home had not fully completed the staff training ordered by compliance order #002 under inspection report #2017_642606_0005.

The severity of this finding is potential for harm related to failure to ensure that staff used safe transferring and positioning techniques when assisting residents.
The scope is pattern, as not all direct care staff members received the required education. Review of the home's compliance history revealed that a compliance order was issued under s.36 on an identified date, under inspection report #2017_642606_0005. [s. 36.]

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are monitored during meals, including residents eating in locations other than dining rooms.

On an identified date, during an identified meal service, inspector #116 observed the entire meal service and noted that resident #001 was not present in the dining room. An interview held with registered staff member #100 indicated that the resident is under contact precautions and will receive tray service after the completion of the meal service.

At the completion of the meal service, inspector #116 observed PSW staff #101 provide the resident a tray at an identified time and left the room shortly thereafter.

Resident #001 was noted to be eating in his/her room unsupervised for a disclosed period of time with no staff monitoring provided during this time period. Upon inquiry the inspector asked resident #001 how they were managing with the meal of which the resident indicated they were fair.

Review of the written plan of care for resident #001 indicates the resident requires supervision when eating to ensure that adequate nutrition is maintained and completion of meals.

Interviews held with PSW staff #101 and registered staff #100 acknowledged being aware of the resident's requirement to be supervised during meals.
Further interview held with the DOC confirmed that all residents are to be monitored during meals including those eating in locations other than dining areas. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are monitored during meals, including residents eating in locations other than dining rooms, to be implemented voluntarily.

Issued on this 28th day of November, 2017

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) :	SARAN DANIEL-DODD (116)
Inspection No. / No de l'inspection :	2017_378116_0015
Log No. / No de registre :	019215-17, 019219-17, 019220-17, 019222-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 10, 2017
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) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_642606_0005, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

Upon receipt of this compliance order the licensee shall:
1. Identify all residents of the home who require the use of a mechanical lift for transferring. The appropriate sling to be used for each resident that requires a mechanical lift should be identified.
2. Review each resident's identified transfer method with all direct care staff members.
3. Complete previously ordered training under inspection report #2017_642606_0005 and include the following:
i) Provide education and/or re-education on the licensee's safe transferring policy and safe transferring methods for mechanical lifts used in the home to all outstanding and/or remaining direct care staff members.
ii) Provide hands on training to demonstrate that staff use safe transferring and positioning techniques when assisting residents to all outstanding and/or remaining direct care staff members.
iii) implement the audit tool developed entitled "spot checks for transferring of residents" and determine monitoring frequency to ensure that direct care staff are using the appropriate lift and sling in a safe manner.

This plan is to be submitted to: Saran.DanielDodd@ontario.ca no later than November 24, 2017.

Grounds / Motifs :

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order was issued under s.36 on an identified date, under inspection report #2017_642606_0005. [s. 36.] (116)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : SARAN Daniel-Dodd

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