Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 7, 2020	2020_729615_0014	002574-20, 003796-20, 004769-20, 004797-20, 006046-20, 010670-20	Critical Incident System

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
40 Playfair Avenue TORONTO ON M6B 2P9

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

HELENE DESABRAIS (615), AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 15, 16 and 17, 2020.

The following Critical Incidents were inspected during this inspection:
CI C577-000001-20/Log #004769-20 related to falls prevention;
CI C577-000002-20/Log #004797-20 related to falls prevention;
CI C577-000003-20/Log #006046-20 related to falls prevention;
CI C577-000005-20/Log #010670-20 related to falls prevention;
CI C577-000006-20/Log #002574-20 related to falls prevention;
CI C577-000011-20/Log #003796-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, and a Personal Support Worker.

The inspector also made observations of the residents, reviewed the residents' health records, reviewed the home's falls prevention program and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Critical Incident Response
Falls Prevention
Nutrition and Hydration
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that when an incident occurred that resulted in a significant change in a resident’s health condition, they informed the Director of the incident no later than three business days after the occurrence of the incident.

A critical incident (CI) report #C577-000006-20, was submitted to the Ministry of Long Term Care (MLTC) on a specific date, related to a resident's fall with injuries and was transferred to hospital the day after.

A review of a resident's progress notes stated that on a specific date, the hospital notified the home that the resident had sustained a fracture and would have surgery. Six days later the resident returned to the home. Prior to the fall, the resident’s care plan stated they required assistance with transfers and used a device for ambulation. When the resident returned to the home from hospital, the resident’s current care plan stated they required more assistance for transfers and ambulation.

During separate interviews, the Administrator, the DOC, a RN and a PSW, said there was a significant change in the resident’s condition related to transfers and mobility after the fall and that was why they sent the resident to the hospital. The Administrator and the DOC said it was an expectation that the Director would be notified when there was a change in the resident’s condition and they were unsure why the critical incident was reported late.

The licensee failed to ensure that when an incident occurred that resulted in a significant change in a resident’s health condition, they informed the Director of the incident no later than three business days after the occurrence of the incident. [s. 107. (3.1)]

Issued on this 8th day of July, 2020

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

Original report signed by the inspector.