Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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_0013	004172-20	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
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 Complaint inspection.

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

The following complaint was inspected during this inspection:

Complaint Log #004172-20 related to maintenance, responsive behaviours, infection prevention and control, nutrition and hydration, reporting and complaints and staffing credentials.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Maintenance Manager and Programs, the Maintenance Lead, the Registered Dietician, a Registered Nurse, a Registered Practical Nurse and two Personal Support Workers.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, complaint reports, the maintenance program and audits, investigation notes and reviewed specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date, Complaint Log# 004172-20 was submitted to the Ministry of Long Term Care (MLTC) related to responsive behaviours of a resident towards another resident. While reviewing a resident's progress notes it was revealed that on a specific date, an alleged verbal abuse occurred from a visitor to a resident. It was found by the inspector that the home had submitted a Critical Incident (CI) report dated a day after the alleged abuse.

A review of the CI indicated that the home did not immediately report the suspected abuse to the Director.

A review of the home's policy #RC-02-01-02 last updated June 2019 stated in part "Reporting: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on Shift at that time. Note: In Ontario, in addition of the above, anyone who suspects or witnesses abuse[...] and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through the Action line."

During interviews, a Registered Practical Nurse and a Personal Support Worker both stated that they would immediately report suspicion of abuse to the home's management team and the MLTC.

During interviews, the Administrator and the Director of Care both stated that the home's expectation was to report suspicion of abuse immediately to the Director.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone occurred, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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.