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

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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 21, 2021	2021_644535_0005 (A1)	024165-19, 020462-20, 020520-20, 021142-20, 021734-20, 023411-20, 023413-20, 023535-20, 023584-20, 025414-20, 000102-21, 000814-21, 001612-21, 003279-21	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

Amended by JOY IERACI (665) - (A1)

Amended 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): February 23, 24, 25, 26, March 1 - 5, 8- 12, 16-19, and off-site March 23-26, April 1,5, 6, 7, 2021.

The following intakes were completed during this inspection:

Log #024165-19 was related to compliance order #001 from inspection #2019_751649_0019 regarding s. 19 (1), with compliance due date September 24, 2020;

Log #020462-20, #020520-20, #021734-20, #023413-20, #023535-20 and #001612-21 were related to abuse,

Log #021142-20 and #003279-21 were related to responsive behavior,

Log #023411-20 was related to improper feeding/positioning,

Log #023584-20 was related to falls,

Log #025414-20 was related to improper care,

Log #000102-21 was related to Improper screening at entrance, and

Log #000814-21 was related to improper consent.

NOTE: A Written Notification and Compliance Order related to LTCHA, s.19 (1)

and s. 6 (10) b and a Voluntary Plan of Correction related to s. 30 (2) were identified in a concurrent inspection #2021_644535_0004 (Log #019953-20, CIS#3020-000026-20; #017501-20, CIS #3020-000026-20; #025742-20, CIS#3020-000051-20) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Resident Services (DRS), Physician, Director of Nursing Unit (DNU), Director Housekeeping and Laundry, Social Worker (SW), Recreation Manager, Pharmacist, Physiotherapist (PT), Responsive Behavior Lead, Resident Assessment Instrument Coordinator (RAI-C), registered staff (RN/RPN), Recreations Aides, personal support workers (PSWs), substitute decision-makers (SDM) and residents.

During the course of the inspection, the inspector conducted observations on all resident care units, observed resident to resident and staff to resident interactions, reviewed clinical health records, staff schedules, internal investigation records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours

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

12 WN(s)
7 VPC(s)
5 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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident was taking prescribed drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The resident was taking a prescribed drug for which the physician ordered a specific monitoring intervention twice daily. The resident's electronic medication records were reviewed and it was noted that on multiple identified dates, the monitoring intervention was completed only once daily or not completed at all.

The RPN verified that the monitoring intervention should have been completed twice daily as prescribed by the physician.

Sources : Resident's EMAR, physician orders, monitoring documentation, interviews with RPN and others. [s. 134. (a)]

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that, if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water.

The home's water temperature monitoring logs were reviewed and it was noted that on multiple instance over a period of three months, the staff did not monitor and document the information required. This was a widespread issue, which affected multiple resident home areas.

The Director of Housekeeping and Laundry Services (DHLS) verified that the monitoring information should have been monitored and documented in the logs located on all resident home areas during each shifts by the housekeeping staff and PSWs.

Source: Monitoring logs, interview with DHLS and others. [s. 90. (2) (k)]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote four residents' rights to be treated with courtesy and respect and in a way that fully recognized their

individuality and respected their dignity.

A resident who resided on an identified resident home area reported that a co-resident frequently displayed disturbing responsive behaviors. The resident stated that the co-resident displayed other responsive behaviors which were disruptive to other residents who resided on the same home area. They reported their concerns to the home's management and the Resident Council, but felt their concerns were not addressed.

The Director of Nursing Unit (DNU) acknowledged that the resident reported their concerns multiple times. The co-resident's behaviors were not well managed and continued to disturb the above resident.

Sources : CIS report, interviews with resident, DNU and others. [s. 3. (1) 1.]

2. A second resident on the resident home area also stated that the above co-resident's responsive behaviors triggered other residents, causing negative reactions.

Again, the DNU acknowledged that the second resident reported their concerns multiple times. The co-residents behaviors were not well managed triggering other residents on the home area.

Sources : CIS report, interviews with resident, DNU and others. [s. 3. (1) 1.]

3. A resident's substitute decision-maker reported that multiple personal belongings were misplaced and were not accessible to the resident. Missing items were not located and returned during the resident's entire stay.

The resident was isolated because of COVID-19 protocol, but co-residents responsive behaviors caused the resident negative affects during isolation. The resident became less responsive, displayed responsive behaviors and became disengaged from home activities. Therefore, the home failed to respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

Sources: Resident's progress notes, BSO consultation notes, Activity Pro records, interviews with RPNs, Program Manager, SDM and others. [s. 3. (1) 1.]

4. The licensee has failed to ensure the resident's right to give or refuse consent related to care and treatment was fully respected.

A DNU presented the resident with a blank consent form and requested that they sign the document in order to receive a prescribed intervention when it became available.

The resident's native language was different from the language in which the form was written. The resident signed and dated the blank consent form, then reported the incident to their SDM stating that they had signed for something they were not sure about.

The DNU acknowledged that they thought the resident was able to understand and sign the form in that written language. However they discovered that the resident's plan of care listed a different native language. Therefore, the resident was unable to understand the consequences of giving or refusing consent as the information was not presented in their native language.

Sources : Consent form, progress notes, email communication and interview with SDM, DNU and others. [s. 3. (1) 11. ii.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 residents were free from neglect by the licensee or staff in the home.

Section s. 2 (1) of the Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A complaint was received by the MLTC regarding improper care of residents, including neglect.

At admission, the resident had no identified responsive behaviors, used a mobility device and required support with all activities of daily living.

Registered staff initially documented that the resident was engaged and adjusting well to the environment. Weeks later, staff documented that the resident was displaying responsive behaviors, however the resident was not referred to the home's internal BSO team or the external BSO resource team for an assessment to manage their new or worsened responsive behaviors.

The resident could have benefited from a collaborative team approach to manage their behavior and their unstable medical diagnosis. Months after the resident had been admitted to the home, the RPN submitted a pharmacy referral and the pharmacist made a number of significant recommendations to manage the resident's unstable medical diagnosis.

The physician had ordered a monitoring intervention twice daily related to the unstable diagnosis, however registered staff did not consistently complete the resident's monitoring intervention twice daily as prescribed. There were multiple days when no monitoring intervention was completed or the monitoring was done only once daily.

The RPN acknowledged that the resident's monitoring intervention should have been completed at least twice daily and as needed (PRN). After conducting a review of the resident's medication record, the home's pharmacist recommended a significant increase in the monitoring interventions and medication adjustments related to the resident's unstable diagnosis.

The resident experienced incidents of known and unknown injuries during their stay. They were offered as needed pain medication, however the resident could have benefited from scheduled doses of analgesic medication to promote consistent comfort, and a weekly pain assessment was not initiated until weeks later.

The home's physiotherapist (PT) and the registered staff both acknowledged that the resident would have benefited from a specific falls prevention intervention since the use of that falls prevention strategy could have prevented their falls and subsequent injuries.

Therefore, the resident did not receive the treatment and care as were required to manage their diagnosis and activities and this pattern of inaction jeopardized their health causing actual harm.

Sources : CIS reports, resident’s progress notes, EMARs, clinical assessments, Interviews with Physician, Pharmacist, PT, RPN and others. [s. 19. (1)]

2. A resident's clinical assessment indicated that they had a specific responsive behavior related to their diagnosis.

The primary RPN was informed that the physician had ordered a specific device to be used to prevent the resident from engaging in their responsive behaviors. The specific device was not available in the home area, therefore the RPN used other materials instead of the specific device which was ordered by the physician.

The RPN stated that the resident was not compliant with the previous intervention which prompted their decision to use other materials to manage their behavior. They also indicated that they had forgotten to report the use of the other materials as an intervention to prevent the resident's behavior. The RPN stated that they had requested an order for the specific device to manage the resident's behavior

since the previous week.

The BSO team member was not aware of the resident's behavior since an electronic referral related to the resident's new or worsening responsive behavior was not completed and sent to the BSO team. They also verified that after the incident, the resident was assessed by the home’s internal BSO team and external BSO resources, had changes to their medication and the resident's behaviors were improved.

Sources: CIS report, home’s investigation notes, resident’s progress notes, EMARs, skin and wound assessments, interviews with RPN, RN, PSW, BSO team member and others. [s. 19. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #5: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's plan of care was based on their

needs and preferences.

The resident's substitute decision-maker (SDM) reported that the assigned PSW provided care roughly and that another PSW had witnessed the incident.

The PSW who witnessed the incident stated that the assigned PSW was working quickly and had not informed the resident regarding the care being provided. They stated that the PSW provided the same care consistently to all residents, however they also acknowledged that the pace at which the PSW provided the care was quicker than the resident liked their care to be provided. The assigned PSW had not worked with the resident before.

The PSW stated that they approached the assigned PSW afterwards and informed them that they needed to slow down when providing care, and the PSW accepted the comment favorably. They also verified that the resident's plan of care should have included the resident's preference so that all staff would provide care in a consistent manner for the resident.

Source: CIS report, resident's written care plan, interview with SDM, PSW and others. [s. 6. (2)]

2. The licensee has failed to ensure staff and others involved in the different aspects of a resident's care collaborated with each other in the assessment of the resident, so that their assessments were integrated, consistent with and complemented each other.

The resident was prescribed multiple medications related to their unstable diagnosis. The admitting registered staff had noted that the resident should have clinical monitoring more frequently, at least three times daily, however this suggestion was not endorsed to the physician. The physician and pharmacist did not collaborate related to the resident's medication review and management of their unstable diagnosis due to the COVID-19 outbreak in the home. The physician stated that the resident's clinical monitoring results were unstable and it was challenging to manage their diagnosis.

Although the resident was displaying multiple new or worsening responsive behaviors, registered staff did not complete and send an electronic behavioral referral to the BSO team for assessment and support.

Therefore, the home failed to ensure that registered staff, physician, pharmacist and the BSO team collaborated with each other in the assessment of the resident, so that their assessments were integrated, consistent with and complemented each other.

Sources : Resident’s EMAR, progress notes, clinical assessments, interviews with BSO team member, Pharmacist, Physician and others. [s. 6. (4) (a)]

3. The licensee has failed to ensure that a resident's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

On an identified date, the registered staff documented that the resident sustained an unwitnessed injury. A few hours later that same day, the resident sustained another injury which required them to be transferred to hospital for further assessment and treatment.

The resident's SDM stated that they were called and informed that the resident was transferred to hospital as a result of an injury, however they were not made aware that the resident also had sustained a previous unwitnessed injury.

When the resident returned to the home following treatment at the hospital, the resident was non-compliant with the treatment regime, however the home did not notify the family that the resident was not complying with the treatment.

The RPN confirmed that the family should have been made aware the resident was being non-compliant with the treatment since maybe they could have convinced the resident to be compliant, and also that the resident had sustained an unwitnessed injury.

Sources: Resident's progress notes, interviews with SDM, RPN, and others. [s. 6. (5)]

4. The licensee has failed to ensure that three residents were reassessed and the plan of care reviewed and revised when the resident’s care needs changed.

One resident was at risk for falls, and sustained an unknown injury and two falls with two separate injuries during their stay in the home.

The home's Physiotherapist (PT) and RPN stated that the resident's care plan should have been reviewed and revised after the the first fall incident and a specific falls prevention intervention should have been implemented to alert the staff and minimize the risk of falls and injuries.

Sources: CIS report, resident's progress notes, hospital consult notes, interviews with PT, RPN and others. [s. 6. (10) (b)]

5. A second resident was at risk for falls. Over an identified period, the resident experienced two falls, was transferred to hospital on both occasions and sustained two separate injuries.

The primary PSW verified that the resident had a specific falls prevention intervention in place, however they would have benefited from a second specific intervention as well. The PSW indicated that they were worried that the resident would hurt themselves and acknowledged that if staff were alerted that could have prevented the resident's falls and subsequent injuries.

Sources : CIS report, resident's Falls Risk Assessment, progress notes, hospital consult notes, interviews with PSWs and others. [s. 6. (10) (b)]

6. A third resident exhibited responsive behaviors, and that were assessed and being followed by the home's BSO Team.

The RPN stated that they repeatedly provided an intervention to the resident, however they were non-compliant as a result of their responsive behaviors.

Although the resident was being followed and managed by the BSO team, the BSO RPN stated that they did not receive a referral to reassess the resident related to their non-compliant behavior. They acknowledged that they should have received a new referral in order to review and revise the resident's plan of care to manage their new responsive behaviors.

Sources : CIS report, resident's BSO admission assessment, Dementia Observation System (DOS) monitoring, weekly skin and wound assessment records, cell phone image, progress notes, interview with RPN, BSO team member and others. [s. 6. (10) (b)]

7. The licensee has failed to ensure that a resident was reassessed and the plan

of care revised because care set out in the plan had not been effective, and had different approaches considered in the revision of the plan of care.

The resident exhibited disruptive responsive behaviors. The SDM of a co-resident reported that the resident would enter their family member's room frequently, which negatively affected them.

The resident was referred to the home's BSO team and the external BSO resources team to manage their behaviors. Interventions to manage the behaviors were in place, though they were ineffective.

The BSO team member verified that although the internal BSO team and external behavioral resources were involved, the current interventions were ineffective. The resident should have been reassessed and the plan of care revised and different approaches should have been considered.

Sources : Resident's progress and consultation notes, interviews with SDM, RPN and others. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to two residents under the falls prevention program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A resident was found in their bed with an injury to an identified part of the body. The registered staff documented the injury, provided treatment and initiated a clinical monitoring record as per the home's policy. Later that same day, the resident sustained another injury for which they were transferred to hospital for assessment and treatment.

The resident returned to the home, registered staff continued to use the same clinical monitoring record which was initiated related to the injury of unknown cause. There was no documentation to indicate that the resident sustained a second injury which required clinical monitoring and which caused them to be transferred to hospital.

The RPN stated that clinical monitoring documentation was to continue for 72 hours as indicated in the home's policy. They also verified that there should have been another clinical monitoring record initiated for the resident's second injury, and they should have been reassessed with a baseline clinical monitoring documented when they returned from hospital and continued for 72 hours from the time of their injury.

Sources : Clinical Monitoring Protocol, resident’s clinical monitoring records, progress notes, paper chart review, interview with RPN and others. [s. 30. (2)]

2. Another resident experienced four falls in the home. They sustained an injury after the fourth fall which required transfer to hospital and was diagnosed with an injury.

The home's Clinical Monitoring Record indicated that the resident should have been monitored frequently for a period of 72 hours. After the resident returned from hospital, the clinical monitoring was not completed as required.

The RPN verified that the resident should be have been assessed and all time

slots on the clinical monitoring record should have been completed by registered staff for 72 hours.

Sources : CIS report, resident's Clinical Monitoring Record, interview with RPN and others. [s. 30. (2)]

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 the resident's clinical monitoring record was complete and the resident's response to interventions were documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by the initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The resident sustained an injury which required transfer to hospital, and was diagnosed with an injury. They returned to the home with an analgesic prescription which was administered as needed. Registered staff documented the resident's complaint and administered medication. A pain assessment was not completed using a clinically appropriate assessment instrument until weeks later; and staff did not notify the physician to prescribe a scheduled dose of medication to support a consistent level of comfort for the resident.

The RPN acknowledged that the resident should have had weekly clinically appropriate pain assessment initiated soon after they returned from hospital.

Sources : Resident's pain assessments, progress notes, interview with RPN and others. [s. 52. (2)]

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 when a resident's pain was not relieved by the initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A Recreation Aide (RA) stated that a resident had previously uttered threatening words toward a co-resident. The situation between the two residents escalated when the resident who made the threats, pushed the co-resident's mobility device as they went by them. The resident who engaged in making threats and pushing the mobility device was assessed by the home BSO Team and assigned close monitoring to prevent further altercations.

The RA and the BSO team member acknowledged that the home did not identify and implement interventions to prevent the risk of altercation and potentially harmful interactions between both residents after the first incident occurred.

Sources : CIS report, resident’s progress and consultation notes, interviews with RA, BSO team member and others. [s. 54. (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 steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #012's assessment indicated that they had multiple responsive behaviors. Staff were advised to call a code white if their behaviors escalated to ensure residents and staff protection and safety.

Resident #012's responsive behavior was triggered by a sound, and they entered resident #001's room and used a mobility device in an attempt to silence the sound. Resident #001 was not harmed, however their SDM reported the incident to the home's management and applicable authorities. Resident #012 was

warned not to enter other residents' personal space while residing in the home.

The BSO team member verified that resident #012's triggers were identified during a behavior assessment in the past. They also acknowledged that some of the interventions previously recommended were not implemented to prevent further altercations with other residents.

Sources: Resident's progress notes, consultation notes, social worker referral notes, interviews with SDM, BSO team member and others. [s. 55. (a)]

2. The Recreation Aide (RA) stated that resident #009 was admitted to an identified resident home area years ago, and that their displayed responsive behaviors had progressed to being disruptive for other residents and they were concerned for their safety.

Resident #009's assessment indicated that they had identified responsive behaviors. The home attempted to implement various behavioral strategies recommended by the internal and external behavioral support teams. Resident #009's behaviors triggered resident #011's responsive behavior which resulted in two negative interactions between them.

The BSO team member verified that resident #009 was referred to the Geriatric Mental Health Outreach Team (GMHOT) and the psycho-geriatritician, however al recommendations were declined and the resident's behaviors continued to provoke triggers and altercations with other residents.

The home's Executive Director (ED), Director of Resident Services (DRS) and the Director of Nursing Unit (DNU) were engaged with the family to develop a new action plan.

Sources: Resident's progress notes, BSO consultation notes, interviews with various residents, DRS, DNU, BSO team member and others. [s. 55. (a)]

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 procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #10: 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:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was given sufficient time to eat at their own pace.

The resident informed their SDM and the RPN that a PSW rushed them when assisting with feeding, which caused them some discomfort. A review of the consultation notes indicated that a Speech Language Pathologist (SLP) wrote specific recommendations related to providing feeding assistance to the specific resident, which were not adhered to by the PSW.

The RPN verified that they observed that the PSW had not adhered to some of the recommendations, and supported the resident's care by discussing the details with the PSW.

The home provided additional education and training to the PSW involved related to providing residents feeding assistance.

Source: Home’s investigation notes, progress notes, SLP consult notes, interview with SDM, RPN and others. [s. 73. (1) 7.]

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 given sufficient time to eat at their own pace, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident's clothing were labelled and acquired in a dignified manner within 48 hours of admission.

The resident was admitted to the home during the COVID-19 Pandemic. There were changes made to the process of receiving and labeling newly admitted resident's personal belongings. The residents belonging were misplaced, and remained missing for weeks during their stay.

The resident's SDMs and PSW verified that the resident's personal belongings were not labelled and acquired within 48 hours of their admission to the home.

Sources : Inventory List, Missing Items Form, email communications between family and management, interviews with SDM, RPN and others. [s. 89. (1) (a) (ii)]

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 residents clothing are labelled and acquired in a dignified manner within 48 hours of admission, to be implemented voluntarily.

WN #12: 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 a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

The resident's electronic medication administration record (eMAR) indicated they were prescribed scheduled and as needed (PRN) medications to control their unstable diagnosis, which required close monitoring.

On two different identified dates, the resident's monitoring result was elevated beyond the targeted level, and instead of administering the prescribed medication as ordered, registered staff encouraged the resident to use an alternative method of treatment.

The RPN verified that the resident was prescribed medication for treatment of elevated monitoring levels, and that the medication should have been administered as prescribed. They also stated that considering the level of elevation, the physician should have been notified.

Sources : Resident's EMAR, progress notes, physician's order, interview with RPN and others. [s. 131. (2)]

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 drug was administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 21st day of July, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 Operations Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JOY IERACI (665) - (A1)
Inspection No. / No de l'inspection :	2021_644535_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	024165-19, 020462-20, 020520-20, 021142-20, 021734-20, 023411-20, 023413-20, 023535-20, 023584-20, 025414-20, 000102-21, 000814-21, 001612-21, 003279-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 21, 2021(A1)
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 40 Playfair Avenue, Toronto, ON, M6B-2P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Toni Dell'Aquila

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

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

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 # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must comply with s. 134 of the O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure all residents with a specific diagnosis receive monitoring as ordered by their attending physician; and results to be documented in the home's electronic documentation system.

2. Conduct audits twice weekly for one month to ensure registered staff adhere to the protocol above. Documentation of the audit must include the date, resident's name, care unit, person conducting the audit, result of each audit and actions taken as applicable. A record of all audits must be made available upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that when the resident was taking prescribed drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The resident was taking a prescribed drug for which the physician ordered a specific monitoring intervention twice daily. The resident's electronic medication records were reviewed and it was noted that on multiple identified dates, the monitoring intervention was completed only once daily or not completed at all.

The RPN verified that the monitoring intervention should have been completed twice daily as prescribed by the physician.

Sources : Resident's EMAR, physician orders, monitoring documentation, interviews with RPN and others. [s. 134. (a)]

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the resident since the resident was prescribed multiple medications to control their unstable diagnosis and registered staff did not monitor the resident's monitoring levels as prescribed by the physician.

Scope: The scope of this non-compliance was isolated to one resident.

Compliance History: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2021

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must comply with s. 90 (2) of the O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the water temperature serving specific resident home areas is monitored and documented in the designated log book on each resident home area.

2. Conduct audits twice weekly for one month to ensure staff adhere to the protocol above. Documentation of the audit must include the date, resident home area, person conducting the audit, result of each audit and actions taken as applicable. A record of all audits must be made available upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that, if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water.

The home's water temperature monitoring logs were reviewed and it was noted that on multiple instances, over a period of three months, the staff did not monitor and document the information required. This was a widespread issue, which affected multiple resident home areas.

The Director of Housekeeping and Laundry Services (DHLS) verified that the monitoring information should have been monitored and documented in the logs located on all resident home areas during each shifts by the housekeeping staff and PSWs.

Source: Monitoring logs, interview with DHLS and others. [s. 90. (2) (k)]

An order was made by taking the following factors into account:

Severity: The severity was determined to be minimal risk of harm to residents.

Scope: The scope of this non-compliance was widespread since it was determined that three resident home areas reviewed in the home were affected.

Compliance History: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2021

Order # / No d'ordre: 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must comply with s. 3 (1) of the LTCHA, 2007.

Specifically, the licensee must:

1. Ensure all affected residents are treated with respect and dignity. The home's social worker to engage with each resident in conversation and document their comments/feedback regarding the resolution of their previous concerns on the identified resident home area.

2. Develop and implement strategies to prevent identified residents from wandering into other resident's rooms to prevent potentially harmful verbal and physical interactions. Document the process for review.

3. Ensure registered staff and PSWs are aware of the home's new process for receiving, labeling and distributing new residents personal belongings upon admission to the home. Similarly, the above staff should be familiar with the process of finding resident's lost or missing personal belongings. Document both processes used to re-educate staff, for review.

Grounds / Motifs :

1. The licensee has failed to fully respect and promote three residents' rights to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

A resident who resided on an identified resident home area reported that a co-resident frequently displayed disturbing responsive behaviors. The resident stated that the co-resident displayed other responsive behaviors which were disruptive to other residents who resided on the same home area. They reported their concerns to the home's management and the Resident Council, but felt their concerns were not addressed.

The Director of Nursing Unit (DNU) acknowledged that the resident reported their concerns multiple times. The co-resident's behaviors were not well managed and continued to disturb the above resident.

Sources : CIS report, interviews with resident, DNU and others. [s. 3. (1) 1.] (535)

2. A second resident on the resident home area also stated that the above co-resident's responsive behaviors triggered other residents, causing negative reactions.

Again, the DNU acknowledged that the second resident reported their concerns multiple times. The co-residents behaviors were not well managed triggering other residents on the home area.

Sources : CIS report, interviews with resident, DNU and others. [s. 3. (1) 1.]
(535)

3. A resident's substitute decision-maker reported that multiple personal belongings were misplaced and were not accessible to the resident. The missing items were not located and returned during the resident's entire stay.

The resident was isolated because of COVID-19 protocol, but co-residents responsive behaviors caused the resident negative affects during isolation. The resident became less responsive, displayed responsive behaviors and became disengaged from home activities. Therefore, the home failed to respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

Sources: Resident's progress notes, BSO consultation notes, Activity Pro records, interviews with RPNs, Program Manager, SDM and others. [s. 3. (1) 1.]

An order was made by taking the following factors into account:

Severity: The severity was determined to be minimum harm or risk to residents.

Scope: The scope of this non-compliance was a widespread because three residents were affected.

Compliance History: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2021

Order # / No d'ordre: 004

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

Linked to Existing Order / Lien vers ordre existant: 2019_751649_0019, CO #001;

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 must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The compliance plan shall include but is not limited to the following:

1. Measures to ensure registered staff complete an electronic referral to alert the home's BSO team when residents are observed displaying new or worsened responsive behaviors so that interventions are set in place to prevent harmful interactions. And, ensure the BSO Team are involved with the care of all residents who are assigned one to one PSW monitoring for consistent and timely follow ups when concerns are identified.

2. Measures to ensure consistent and timely monitoring of all residents with a specific diagnosis as ordered by the physician.

3. Measures to ensure all residents with a fall history receive an interdisciplinary assessment and implementation of appropriate interventions to prevent falls and injuries.

4. A record is required to be kept by the licensee for all actions undertaken and audits completed for the above items.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each objective/goal listed in the plan.

Please submit the written plan for achieving compliance to the LTC Home Inspector: Veron Ash, MLTC, by July8, 2021 via email to: TorontoSAO.moh@ontario.ca. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. Compliance Order (CO) #001 from inspection #2019_751649_0019 served on November 25, 2019, with a compliance date of September 24, 2020 (A2) is being re-issued as follows:

A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's abuse program.

During the current inspection, the following findings were noted:

The licensee has failed to ensure two residents were free from neglect by the licensee or staff in the home.

Section s. 2 (1) of the Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A complaint was received by the MLTC regarding improper care of residents, including neglect.

At admission, the resident had no identified responsive behaviors, used a mobility device and required support with all activities of daily living.

Registered staff initially documented that the resident was engaged and adjusting well to the environment. Weeks later, staff documented that the resident was displaying responsive behaviors, however the resident was not referred to the home's internal BSO team or the external BSO resource team for an assessment to manage their new or worsened responsive behaviors.

The resident could have benefited from a collaborative team approach to manage their behavior and their unstable medical diagnosis. Months after the resident had been admitted to the home, the RPN submitted a pharmacy referral and the pharmacist made a number of significant recommendations to manage the resident's unstable medical diagnosis.

The physician had ordered a monitoring intervention twice daily related to the unstable diagnosis, however registered staff did not consistently complete the

resident's monitoring intervention twice daily as prescribed. There were multiple days when no monitoring intervention was completed or the monitoring was done only once daily.

The RPN acknowledged that the resident's monitoring intervention should have been completed at least twice daily and as needed (PRN). After conducting a review of the resident's medication record, the home's pharmacist recommended a significant increase in the monitoring interventions and medication adjustments related to the resident's unstable diagnosis.

The resident experienced incidents of known and unknown injuries during their stay. They were offered as needed pain medication, however the resident could have benefited from scheduled doses of analgesic medication to promote consistent comfort, and a weekly pain assessment was not initiated until weeks later.

The home's physiotherapist (PT) and the registered staff both acknowledged that the resident would have benefited from a specific falls prevention intervention since the use of that falls prevention strategy could have prevented their falls and subsequent injuries.

Therefore, the resident did not receive the treatment and care as were required to manage their diagnosis and activities and this pattern of inaction jeopardized their health causing actual harm.

Sources : CIS reports, resident's progress notes, EMARs, clinical assessments, Interviews with Physician, Pharmacist, PT, RPN and others. [s. 19. (1)]
(535)

2. A resident's clinical assessment indicated that they had a specific responsive behavior related to their diagnosis.

The primary RPN was informed that the physician had ordered a specific device to be used to prevent the resident from engaging in their responsive behaviors. The specific device was not available in the home area, therefore the RPN used other materials instead of the specific device which was ordered by the physician.

The RPN stated that the resident was not compliant with the previous intervention which prompted their decision to use other materials to manage their behavior. They

also indicated that they had forgotten to report the use of the other materials as an intervention to prevent the resident's behavior. The RPN stated that they had requested an order for the specific device to manage the resident's behavior since the previous week.

The BSO team member was not aware of the resident's behavior since an electronic referral related to the resident's new or worsening responsive behavior was not completed and sent to the BSO team. They also verified that after the incident, the resident was assessed by the home's internal BSO team and external BSO resources, had changes to their medication and the resident's behaviors were improved.

Sources: CIS report, home's investigation notes, resident's progress notes, EMARs, skin and wound assessments, interviews with RPN, RN, PSW, BSO team member and others. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was actual harm and risk of harm to residents as a result of the falls and responsive behavior incidents.

Scope: The scope of this non-compliance was a pattern since two residents were affected.

Compliance History: The licensee continues to be in non-compliance with s. 19 (1) of the LTCHA, 2007, resulting in a compliance order (CO) being re-issued. CO #001 was issued on November 25, 2019, (Inspection #2019_751649_0019) with a compliance due date of September 24, 2020 (A2). (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2021(A1)

Order # / No d'ordre: 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6 (10) of the LTCHA, 2007.

Specifically, the licensee must:

1. Ensure direct care staff (PSWs and registered staff) and the Falls Lead review falls prevention strategies for all residents identified as high risk for falls, to determine if the strategies are effective to prevent falls and minimize injuries to residents.

2. Ensure a new or worsening behavior referral is completed and submitted to the home's internal BSO Team, using the electronic documentation system, when a resident displays a new or worsening responsive behavior.

3. Conduct audits twice weekly for one month to ensure registered staff adhere to both protocols listed above. Documentation of the audit must include the date, resident's name, resident care unit, person conducting the audit, result of each audit and actions taken as applicable. A record of all audits must be made available upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that three residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed.

One resident was at risk for falls, and sustained an unknown injury and two falls with two separate injuries during their stay in the home.

The home's Physiotherapist (PT) and RPN stated that the resident's care plan should have been reviewed and revised after the the first fall incident and a specific falls prevention intervention should have been implemented to alert the staff and minimize the risk of falls and injuries.

Sources: CIS report, resident's progress notes, hospital consult notes, interviews with PT, RPN and others. [s. 6. (10) (b)]
(535)

2. A second resident was at risk for falls. Over an identified period, the resident experienced two falls, was transferred to hospital on both occasions and sustained two separate injuries.

The primary PSW verified that the resident had a specific falls prevention intervention in place, however they would have benefited from a second specific intervention as well. The PSW indicated that they were worried that the resident would hurt themselves and acknowledged that if staff were alerted that could have prevented the resident's falls and subsequent injuries.

Sources : CIS report, resident's Falls Risk Assessment, progress notes, hospital consult notes, interviews with PSWs and others. [s. 6. (10) (b)] (535)

3. A third resident exhibited responsive behaviors, and that were assessed and being followed by the home's BSO Team.

The RPN stated that they repeatedly provided an intervention to the resident, however they were non-compliant as a result of their responsive behaviors.

Although the resident was being followed and managed by the BSO team, the BSO RPN stated that they did not receive a referral to reassess the resident related to their non-compliant behavior. They acknowledged that they should have received a new referral in order to review and revise the resident’s plan of care to manage their new responsive behaviors.

Sources : CIS report, resident’s BSO admission assessment, Dementia Observation System (DOS) monitoring, weekly skin and wound assessment records, cell phone image, progress notes, interview with RPN, BSO team member and others. [s. 6. (10) (b)]

An order was made by taking the following factors into account:

Severity: There was actual harm and risk of harm to residents because of the falls and responsive behavior incidents.

Scope: The scope of this non-compliance was widespread since three residents were affected.

Compliance History: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 15, 2021

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 21st day of July, 2021 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by JOY IERACI (665) - (A1)

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