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
Jan 27, 2022	2021_642698_0021	016108-21, 019394-21	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

ORALDEEN BROWN (698)

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): December 1-3, 2021.

The following intakes were completed during this complaint inspection:
Log # 016108-21 related to responsive behaviors and log #019394-21 related to Residents' Bill of Rights.

During the course of the inspection, the inspector(s) spoke with the Nurse Manager (NM), Registered Practical Nurse (RPN) Personal Support Worker (PSW) and residents.

During the course of the inspection, the inspector conducted observations of residents, staff and resident interactions, and the provision of care; conducted review of resident health records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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:
3. Every resident has the right not to be neglected by the licensee or staff. 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:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 had the right to have their lifestyle and choices respected.

A complaint was received related to resident #001 not being offered lifestyle choices.

Care plan indicated that resident #001 required total assistance with personal support services and dependent on the use of an ambulatory aide.

Resident #001 indicated that staff did not offer them a choice with activities of daily living and that this occurred almost daily.

An RPN acknowledged that resident #001 made several requests to staff regarding their lifestyle and choice. However, staff did not grant the resident their requests. NM indicated that staff were expected to meet the care needs of all residents.

Staff neglected resident #001's rights when they were not offered a choice and denied their request in lifestyle and choices.

Sources: Resident #001's electronic health records, interviews with resident #001, RPN #110 and NM #104. [s. 3. (1) 19.]

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 resident #001 and others have their rights to lifestyle and choices respected, to be implemented voluntarily.

WN #2: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #019 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

Non-compliance was identified with resident #001 under Resident's Bill of Rights. Resident #016 and #019 were reviewed to expand the resident sample.

Resident #019 indicated that they did not receive assistance with an activity of daily living when they requested it and sometimes waited for an extended period to have their care needs met by staff, upon their return from break.

Review of the clinical records indicated that resident #019 was receiving medications for bowel management. Their plan of care indicated that the resident was continent of bowel and bladder and dependent on staff for assistance with the use of a mechanical device.

A PSW confirmed the resident’s concern of not having their care needs met. NM indicated that staff were expected to meet the care needs of all residents.

Staff did not reassess and update resident #019’s care plan to reflect specific care needs when they delayed care.

Sources: Resident #019 electronic health records, interviews with resident #019, PSW #111 and NM #104.

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 resident #019 is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 2nd day of February, 2022

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

Original report signed by the inspector.