Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 18, 2023	
Inspection Number: 2023-1514-0002	
Inspection Type: Critical Incident System	
Licensee: Villa Colombo Homes for the Aged Inc.	
Long Term Care Home and City: Villa Colombo Homes for the Aged, Toronto	
Lead Inspector Henry Chong (740836)	**Inspector Digital Signature** Henry A Chong Digitally signed by Henry A Chong Date: 2023.01.20 16:13:33 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 6, 9, 10, 12, 16, 2023

The following intake(s) were completed:

- Intake: #00001923-[CI: 3020-000054-21] Fall with injury
- Intake: #00002851-[CI: 3020-000047-21] Fall with injury
- Intake: #00002946-[CI: 3020-000034-21] Fall with injury
- Intake: #00003100-[CI: 3020-000036-21] Fall with injury
- Intake: #00003103-[CI: 3020-000025-21] Fall with injury
- Intake: #00003246-[CI: 3020-000022-21] Fall with injury
- Intake: #00003281-[CI: 3020-000020-21] Fall with injury
- Intake: #00003435-[CI: 3020-000048-21] Fall with injury
- Intake: #00003700-[CI: 3020-000009-21] Fall with injury
- Intake: #00003866-[CI: 3020-000012-21] Fall with injury
- Intake: #00003953-[CI: 3020-000058-21] Fall with injury
- Intake: #00004443-[CI: 3020-000055-21] Fall with injury
- Intake: #00004480-[CI: 3020-000001-22] Fall with injury
- Intake: #00004983-[CI: 3020-000050-21] Fall with injury
- Intake: #00004998-[CI: 3020-000059-21] Fall with injury
- Intake: #00005299-[CI: 3020-000002-22] Fall with injury
- Intake: #00005321-[CI: 3020-000049-21] Fall with injury
- Intake: #00005569-[CI: 3020-000027-22] Fall with injury

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- Intake: #00005839-[CI: 3020-000028-22] Fall with injury
- Intake: #00005927-[CI: 3020-000012-22] Fall with injury
- Intake: #00006047-[CI: 3020-000003-22] Fall with injury
- Intake: #00006716-[CI: 3020-000015-22] Fall with injury
- Intake: #00008611-[CI: 3020-000035-22] Fall with injury
- Intake: #00013734-[CI: 3020-000042-22] Fall with injury

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program. Specifically, the licensee failed to ensure that Routine Practices were followed related to the appropriate application of eye protection and an N95 mask as required by Routine Practices 9.1 (d) under the IPAC Standard.

Rationale and Summary

a) On an identified date, a staff member was observed wearing a surgical mask when exiting a dining room on a unit which was in a suspected COVID-19 outbreak.

The staff member said that they are to wear eye protection and an N95 mask while working on the unit. The IPAC Lead and Clinical Educator stated that all staff are expected to wear eye protection and N95 mask while on the unit as an additional precaution to COVID-19. There was an increased risk of transmission of infection to staff and residents.

Sources: Observations, and interviews with IPAC Lead and Clinical Educator and other staff.

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b) On an identified date, a staff member was observed entering a resident's room on droplet/contact precautions. An enhanced precautions sign was posted on the door indicating the specific personal protective equipment (PPE) to be worn by staff. The staff member wore a surgical mask, gloves, gown, and face shield prior to entering the room, but did not wear an N95 mask.

The staff member stated that they are to wear gown, gloves, N95 mask and face shield when droplet/contact precautions are identified prior to entering the resident's room. The IPAC Lead and Clinical Educator stated that all staff are to don the required PPE prior to entering a resident's room under additional precautions.

There was an increased risk of transmission of infection to staff and residents when staff did not wear the required PPE.

Sources: Observations, and interviews with IPAC Lead and Clinical Educator and other staff.

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WRITTEN NOTIFICATION: Reporting critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)

The licensee has failed to ensure that a disease outbreak which occurred after normal business hours, was immediately reported to the director.

Rationale and Summary

On an identified date, a disease outbreak was declared on a unit. The home reported the incident to the Director on the following day. The IPAC Lead and Clinical Educator acknowledged that the incident was not reported immediately to the after-hours line on the same day.

Sources: CIS report 3020-00002-23, and interview with IPAC Lead and Clinical Educator.

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