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
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: January 31, 2023	
Inspection Number: 2023-1514-0003	
Inspection Type: Complaint 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 Noreen Frederick (704758)	**Inspector Digital Signature**
Additional Inspector(s) Inspector Irish Abecia (000710) was present during this inspection	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 6, 2023
January 9, 2023
January 10, 2023
January 12, 2023
January 13, 2023
January 17, 2023
January 18, 2023
January 19, 2023
January 20, 2023

The following intake(s) were inspected:
- Intake: #00002282-[CI: 3020-000033-21] related to Prevention of Abuse and Neglect
- Intake: #00003184-[CI: 3020-000019-21] related to injury of unknown cause
- Intake: #00013194-Complaint related to Prevention of Abuse and Neglect

• Intake: #00015261-Complaint related to dealing with complaints, improper care, and staffing qualifications

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

Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that the complaints received on an identified date, concerning a resident's care were investigated.

Rationale and Summary

The home received several complaints from a resident's family member concerning the resident's care including an allegation of harm.

The home's policy titled "Complaints and Customer Service" RC-09-01-04, last revised April 2022, stated, "COMPLAINT-A verbal or written expression of grievance or dissatisfaction" (pg. 6). "Respond immediately when a complaint identifies a resident safety or risk of harm issue/potential" (pg. 5). "Initiate an investigation into the circumstances leading to the complaint within 24 hours" (pg. 2).

The Unit Manager stated that they received several emails expressing dissatisfaction towards

the resident's care and one included an allegation of harm. They acknowledged that they did not complete an investigation related to the complaints.

Due to failure to investigate care related complaints, there was a potential risk for the resident to continue receiving poor care.

Sources: complaint emails, home's policy titled "Complaints and Customer Service" RC-09-01-04 (last revised April 2022), interview with Unit Manager.

[704758]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff related to a clinical procedure.

Rationale and Summary

The resident needed a clinical procedure performed by the registered nursing staff for their health and wellbeing. Their care plan stated to perform the procedure as required. The resident preferred a specific supply for this procedure however, on an identified date, the resident refused this procedure as a wrong supply was used. Additionally, on the same day the home received several emails from resident's family member expressing dissatisfaction towards how the resident's clinical procedure was performed.

Registered Practical Nurse (RPN) #101, #104, and Registered Nurse (RN) stated that the resident's care plan did not provide clear directions related to this clinical procedure.

Failure to set out clear directions for the clinical procedure increased potential risk of the resident developing health complications.

Sources: resident's care plan, complaint emails, interviews with RPN #101, #104, and RN.

[704758]

COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with s. 19 (1).

Specifically, the licensee must:

1. Retrain Personal Support Worker (PSW) #110 and #111 related to their roles, and responsibilities for 1:1 monitoring of a resident with high risk responsive behaviours

2. The home must maintain a record of the above education, including the date, content, who facilitated the education, and signed staff attendance.

Grounds
The licensee has failed to ensure that a resident was not neglected.

In accordance with the definition identified in section 5 of the Ontario Regulation 79/10 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

On an identified date and time, a resident displayed an unsafe responsive behaviour and as an intervention, a 1:1 PSW was initiated for that shift by the RN for ongoing monitoring to ensure the safety of the resident. However, the 1:1 PSW was not present to monitor the resident for a period of time. The resident was found by the PSW with a significant change in their health status.

PSW #110 stated that they were assigned to do 1:1 PSW, however they were not present for a period of time. PSW #111 stated that they noticed that the resident did not have a 1:1 PSW. They went into the resident's room and found the resident with a change in their health status. The RN stated that they initiated the 1:1 PSW to ensure the safety of the resident. They acknowledged that because of the 1:1 PSW not being present, the resident did not receive the care and service they required for their safety, which resulted in further harm.

Due to the 1:1 PSW not being present as required, the resident's safety was jeopardized, and they were found with a significant change in their health status.

Sources: resident's clinical records, interviews with PSW #110, #111, and RN.

[704758]

This order must be complied with by February 13, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.