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

Original Public Report

Report Issue Date: March 31, 2023

Inspection Number: 2023-1514-0004

Inspection Type:
Complaint
Follow up
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	**Inspector Digital Signature**
Rodolfo Ramon (704757)	Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2023.04.13 10:09:32 -04'00'

Additional Inspector(s)
Slavica Vucko (210)
Noreen Frederick (704758)

Inspectors Kirthiga Kavindran (000760) and Cindy Cao (000757) attended this inspection during orientation

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):

March 3, 2023
March 6-10, 2023
March 13-17, 2023
March 21-24, 2023

The following intake(s) were inspected:

- Intake: #00019593 - Follow-up related to Prevention of Abuse and Neglect.
- Intake: #00013303 - was related to an injury of unknown cause.
- Intake: #00019779 - was related to improper transferring and positioning techniques resulting in injury.
- Intake: #00015035 was related to abuse.
- Intake: #00021858 was related to a complaint.

- Intake: #00021771 was related to a complaint.

The following intake(s) were completed:
- Intake: #00002513 was related to an injury of unknown cause.
- Intake: #00003868 was related to an injury of unknown cause.
- Intake: #00004117 was related to an injury of unknown cause.
- Intake: #00017146 was related to an injury of unknown cause.
- Intake: #00020019 was related to an unwitnessed fall with injury.
- Intake: #00017248 was related to an unwitnessed fall with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1514-0003 related to LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) inspected by Noreen Frederick (704758)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non compliance with: FLTCA s. 6 (5).

The licensee has failed to ensure that resident #006's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A complaint was sent to the Ministry of Long Term Care related to concerns related to the SDM not being provided an opportunity to fully participate in the planning and implementation of resident #006's plan of care.

During the month of February, resident #006's SDM requested from the licensee, access to review the plan of care and make suggestions regarding the resident's care. The DOC indicated that the SDM was offered an alternative method to participate in the resident's plan of care with a fee, however the SDM requested instead to verbally review the plan of care with the home and provide feedback.

The DOC verified that the SDM was not given an opportunity to review the plan of care.

Sources: The licensee's complaints records, interview with the DOC.
[704757]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of resident #002 was complied with.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report for an allegation of physical abuse the day after its occurrence.

The LTC home's policy "Zero Tolerance of Resident Abuse and Neglect Program", RC-02-01-01 (last reviewed: January 2022) required employees to report immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift of an alleged incident of resident abuse or neglect.

Resident #002 stated that on the day of the incident, a staff had inappropriate physical contact with the resident which resulted in an injury. Staff #102 stated that the resident brought the allegation forward to them. Nurse Manager #108 acknowledged that staff did not comply with LTC home's policy and did not immediately inform the Administrator/designate/reporting manager or the most senior supervisor of resident #002's alleged incident of abuse.

Sources: CIS # 3020-000045-22, the LTC home's policy "Zero Tolerance of Resident Abuse and Neglect Program", RC-02-01-01 (last reviewed: January 2022), and interviews with Resident #002, RPN #102 and Nurse Manager #108.
[704758]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non compliance with: FLTCA s. 26 (1)(c).

The licensee has failed to ensure that any written complaint that it receives concerning the care of a resident is immediately forwarded to the Director.

Rationale and Summary
The MLTC received CIS report #3020-000011-23 related to a complaint regarding resident #005's care. The licensee received the complaint 12 prior to submitting the CIS report. CIS report #3020-000015-23 was also submitted to the Director for complaints sent to the licensee two days prior to the submission of the CIS report in regards to resident #006's care.

According to the licensee's policy Complaints and Customer Service, the licensee was required to forward a copy of the written complaint immediately to the Ministry Long-Term Care. The DOC confirmed on an interview that complaints reported on two CIS reports were not immediately forwarded to the Director.

Sources: CIS report #3020-000011-23, CIS report #3020-000015-23, Complaints and Customer Service Policy #RC-09-01-04 last reviewed on April 2022, interview with the DOC.
[704757]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #007.

Rationale and Summary
A CIS report was submitted to the MLTC regarding resident #007 sustaining an injury of an unknown cause.

On an identified date, resident #007 was transferred using a transferring device. During the transfer, resident #007 sustained an injury.

The home's policy on transferring indicated caregivers were required to actively participate in the transfer. Interviews with staff verified the licensee's policy was not followed as it pertains to active participation during a transfer.

Additionally, a review of resident #007's clinical record showed no assessment was done to determine the appropriate transferring device required to be used for the resident.

Failure to conduct an assessments of resident #007's transfer related to the type of transferring device, and not following the licensee's policy on transferring in regards to active participation of staff led to actual harm in resident #007.

Sources: review of the CIS report, the licensee's policy home's on transferring devices, review of resident #007's clinical record, and interviews with staff.
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The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #005.

Rationale and Summary
A complaint was sent to the MLTC related to care concerns involving resident #005. The complainant alleged that a transfer device was used inappropriately which resulted in resident #005 sustaining an injury. The licensee's complaints records showed that the DOC informed the complainant that a transferring device located in the room at the time of the discovery of the injury, contributed to the injury.

According to the licensee's policy Safe Lifting with Care, an assessment was required to be completed for resident #005 indicating the type of transferring device required to be used. A review of the resident's plan of care revealed no assessment was completed.

The DOC verified no assessment of the transferring device was done for resident #005. Failure to assess resident #005 for a transferring device resulted in actual harm to the resident.

Sources: The licensee's complaints record, policy Safe Lifting with Care RC-08-01-11 reviewed January 2022, resident #005's plan of care and interview with the DOC.
[704757]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2).

The licensee has failed to ensure that when resident #006's pain was not relieved by initial interventions, that they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A complaint was sent to the MLTC regarding multiple areas of concern related to resident #006 including pain management. A review of resident #006's Medication Administration Record (MAR) revealed that they experienced severe pain in the months of February and March 2023. Resident #006 was provided interventions to manage their pain, which were ineffective on multiple occasions.

The licensee's policy Pain Identification and Management indicated that a pain assessment tool was required to be completed when a resident experienced worsening pain. NM #109 and the DOC verified that the clinical pain assessment tool was not completed for resident #006.

Not completing the pain assessment placed the resident at actual risk of inadequate pain management.

Sources: Pain Identification and Management policy #RC-19-01-01 last reviewed on January 2022, resident #006's MAR, interviews with NM #109 and the DOC.
[704757]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b).

The licensee has failed to ensure that standards under the Infection Prevention and Control (IPAC) program were followed by staff, related to providing residents hand hygiene prior to having their meals.

As per the IPAC Standard for Long-Term Care Homes issued April 2022, the Licensee shall ensure that the hand hygiene program included support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting; as well as support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Rationale and Summary
During IPAC observations conducted in the home, residents were observed having their meal without performing hand hygiene. RPN #115 and the IPAC lead stated staff were required to assist residents with hand hygiene before and after every meal.

Failing to perform hand hygiene placed the residents at risk of contracting infectious diseases.

Sources: Hand hygiene policy # IC-02-02-08 last updated on January 2023, IPAC observations, Interviews with RPN #115 and the IPAC lead.

[704757]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #007 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 when a complaint was received regarding resident #006's care, a response was provided within 10 business days of the receipt of the complaint.

Rationale and Summary
A CIS report was submitted to the MLTC regarding care concerns related to resident #006's care. A review of the licensee's complaints records indicated no response was made to the complainant.

The DOC verified on an interview that no response was provided to the complainant.

Sources: The licensee's complaints records, CIS report # CIS 3020-000015-23, interview with the DOC.
[704757]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 1.

The licensee has failed to ensure a report was made in writing to the Director setting out a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

Rationale and Summary
A CIS report was submitted to the MLTC regarding resident #007 sustaining an injury of an unknown cause.

On an identified date, resident #007 was transferred using a transferring device. During the transfer, resident #007 sustained an injury.

NM #109 was not able to present to the inspector on an interview that an official investigation was conducted to determine the cause of the injury. Interviews of staff involved were not conducted.

On a specified date, the triage inspector from the MLTC requested additional information including the type of incident, and the events leading up to the incident and clarification if an investigation is ongoing. A review of the CIS report indicated the information was not provided.

Failure of the home to amend the CIS report with the requested information led to a missed opportunity for the home to conduct an investigation and prevent future unsafe transfer to residents.

Sources: review of CIS report #3020-000049-22, review of resident #007 clinical record, interviews with staff.
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