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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# Original Public Report

**Report Issue Date:** June 16, 2023

**Inspection Number:** 2023-1514-0005

**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** | **Inspector Digital Signature** |
|---|---|
| Ryan Randhawa (741073) | Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2023.06.20 16:43:36 -04'00' |

**Additional Inspector(s)**
Christine Francis (740880)
Cindy Ma (000711)

## INSPECTION SUMMARY

The inspection occurred on the following date(s): May 25-26, 29-31, June 1-2, 5-9, 2023, with May 25-26, 29-31, June 1, 5-9, 2023 conducted on-site and June 2, 2023 conducted off-site.

The following intake(s) were inspected in this Critical Incident System (CIS) inspection:

- Intake: #00011776 - [CI: 3020-000039-22] - related to abuse.
- Intake: #00085845 - [CI: 3020-000035-23] - related to falls prevention and management.
- Intake: #00087705 - [CI: 3020-000043-23] - related to neglect.
- Intake: #00085055 - [CI: 3020-000028-23] - related to injury of unknown cause.
- Intake: #00087997 - [CI: 3020-000044-23] - related to improper care.

The following intake(s) were inspected in this Complaint inspection:

- Intake: #00087316 - related to improper care, falls prevention and management, infection prevention and control.

The following intakes were completed in the CIS inspection

- Intake: #00084155 - [CI: 3020-000022-23], Intake: #00085102 - [CI: 3020-000029-23], Intake: #00085556 - [CI: 3020-000032-23] - related to falls prevention and management.
- Intake: #00084967 - [CI: 3020-000025-23] - related to injury of unknown cause.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
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, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

**Rationale and Summary**

The Director of Resident Services identified that the resident used a device to assist with pressure relief.

The resident's care plan did not identify the device as part of the resident's interventions.

The Director of Resident Services acknowledged that the resident utilized the device, which should be identified in the resident's plan of care, however it was not. They also acknowledged that there were no clear directions provided to staff and others as a result of this intervention not being outlined in the resident's plan of care.

As a result of the home failing to ensure that there was a written plan of care for the resident that set out clear directions to staff and others who provide direct care to the resident, there was a risk that the resident would not be provided with their planned interventions.

**Sources:** Critical Incident Report #3020-000043-23, resident's plan of care, and interview with the Director of Resident Services.
[740880]

## WRITTEN NOTIFICATION: When reassessment, revision is required

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's care plan was revised when the resident's care needs changed.

**Rationale and Summary**

Staff were to implement a fall prevention intervention in a particular resident home area to reduce or mitigate falls for the resident.

The resident had an unwitnessed fall and was found lying on the floor in their room.

A Personal Support Worker and Nurse Manager reported that the resident did not require the fall intervention in that particular resident home area specifically, but rather, in different areas of the home.

The Nurse Manager acknowledged that the intervention specified in the resident’s care plan needed to be revised to reflect the resident’s care needs.

There was risk to the resident of sustaining a fall or an injury when the required interventions were not reflected in the resident’s plan of care when the resident’s care needs changed.

**Sources:** Resident's clinical records; and interviews with a Personal Support Worker and Nurse Manager.
[000711]

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan.

**Rationale and Summary**

The resident required two-person assistance with their activities of daily living (ADL) .

For the month of April, there were 10 days in which the resident was not provided with their correct level of assistance from the staff for the ADL.

A PSW and the Director of Resident Services acknowledged that staff failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan, when the resident was not provided with their correct level of assistance from the staff.

Failure to provide the resident with with the correct level of assistance for their ADL placed the resident at risk for fall or injury.

**Sources:** Review of resident's written plan of care, interviews with the PSW, RN, Director of Resident Services, and other staff.
[741073]

## WRITTEN NOTIFICATION: Directives by Minister

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applied to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that the masking requirements set out in the COVID-19 guidance document for long-term care homes in Ontario, effective April 03, 2023, was complied with.

**Rationale and Summary**

The COVID-19 guidance document for long-term care homes in Ontario required the licensee to ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas.

A PSW was observed not wearing a mask at a nursing station while sitting beside two staff members with a resident sitting across from the nursing station table.

The PSW and the IPAC Lead acknowledged that the PSW should have been wearing a mask at that time.

The IPAC Lead stated there was a risk of transmission of communicable disease to others when the PSW was not wearing a mask, as required by the COVID-19 guidance document for long-term care homes in Ontario.

**Sources:** Observations of PSW, Minister's Directives: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (April 03, 2023), and interviews with PSW, IPAC Lead and other staff.
[741073]

## WRITTEN NOTIFICATION: Required Programs

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee has failed to ensure that the skin and wound care program was implemented in the home for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure there is a written description of the skin and wound care program that includes its goals and objectives and relevant policies, procedures and protocols and is complied with.

Specifically, the home did not refer to the Registered Dietitian when a resident exhibited altered skin integrity as required by the policy.

**Rationale and Summary**

The home's skin and wound policy indicated that a referral to the Registered Dietitian is to be

completed for all residents exhibiting altered skin integrity.

A resident's progress notes identified skin impairment with treatment initiated, however no referral to the Registered Dietitian was noted in the resident's clinical records.

The Registered Dietitian and Nursing Manager both acknowledged that the resident exhibited altered skin integrity, and that a referral to the Registered Dietitian with subsequent assessment should have been completed, however it was not.

There was an increased risk that the resident's skin impairment could have worsened when they presented with altered skin integrity and were not assessed by the Registered Dietitian.

**Sources:** The "Skin and Wound Program: Wound Care Management" policy (last reviewed in January 2022), resident's clinical records, and interviews with the RD and Nursing Manager.
[740880]

## WRITTEN NOTIFICATION: Falls prevention and management

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

**Rationale and Summary**

On a day in February 2023, the resident had a fall.

A Registered Practical Nurse acknowledged that a post-fall assessment was not completed.

The Registered Practical Nurse and Nurse Manager acknowledged that a post-fall assessment should have been completed after the resident fell.

There was risk that the resident would not receive timely treatment when their post-fall assessment was not completed.

**Sources:** Resident's clinical record; and interviews with the Registered Practical Nurse and Nurse

Manager.
[000711]

## WRITTEN NOTIFICATION: Responsive behaviours

**NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that for a resident who demonstrated responsive behaviours, strategies were implemented to respond to these behaviours.

**Rationale and Summary**

There were strategies and interventions to respond to the resident's responsive behaviours.

On a day in October 2022, a PSW was assisting the resident. The resident was displaying responsive behaviours, but despite this, the PSW continued to assist the resident. This interaction resulted in the resident sustaining an injury.

The PSW, a Registered Nurse, Registered Practical Nurse, Nurse Manager and Director of Nursing Services acknowledged that behaviour management strategies as specified in the resident's plan of care should have been implemented to respond to the resident's responsive behaviour.

There was actual harm to the resident when their behaviour strategies were not implemented by the PSW, as the resident sustained an injury.
**Sources:** Resident's plan of care, and interviews with PSW and other staff.
[000711]

## WRITTEN NOTIFICATION: Nutritional care and hydration programs

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to comply with their Food and Fluid Intake policy when a referral was not completed for the registered dietician when a resident consumed 50% or less from all meals for three or more days.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to ensure the nutritional care and hydration program included the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and must be complied with.

Specifically, staff did not comply with the policy "Food and Fluid Intake" dated March 2023, which was included in the licensee's Nutritional Care and Hydration program.

**Rationale and Summary**

A resident was at nutritional risk with ongoing weight loss.

The resident consumed 50% or less from all meals for three days in June 2023.

The home's Food and Fluid Intake policy stated to complete a referral for the registered dietitian when a resident consumed 50% or less from all meals for three or more days.

The Registered Dietitian acknowledged that resident the consumed 50% or less from all meals for three or more days for three days in June 2023 and that a referral to the registered dietitian was not completed as per the home's policy.

Failure to complete a dietary referral in accordance with home's policy, placed the resident at risk for further weight loss.

**Sources:** Review of the home's policy "Food and Fluid Intake" #RC-18-01-01 dated March 2023, the resident's clinical records, progress notes, interviews with the Registered Dietician, and other staff. [741073]