Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: August 16, 2023	
Inspection Number: 2023-1514-0006	
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 Rajwinder Sehgal (741673)	**Inspector Digital Signature**
Additional Inspector(s) Reji Sivamangalam (739633) Chinonye Nwankpa (000715)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 13, 17, 18, 19, 20, 21, 24, 25, 2023
The inspection occurred offsite on the following date(s): July 14, 2023

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

- Intake: #00090113 related to multiple concerns pertaining to a resident's care.

The following intakes were inspected in the Critical Incident System Inspection:

- Intakes: #00089507 - [CI: 3020-000059-23/3020-000062-23], #00091606 - [CI: 3020-000076-23], and #00091858 - [CI 3020-000078-23] related to a resident's care.
- Intake: #00088860 - [CI: 3020-000057-23] related to fracture of unknown cause sustained by the resident.
- Intake: #00090278 - [CI: 3020-000064-23] related to alleged neglect from staff towards a resident.
- Intake: #00091163 - [CI: 3020-000068-23] related to resident's fall.

The following intake(s) were completed in the Critical Incident System Inspection:

- Intake: #00088793 - [CI: 3020-000051-23] related to resident's fall.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure a resident's right to proper nutrition care and services consistent with their needs was fully respected and promoted.

Rationale and Summary
A resident was on a specific nutrition through a medical device. The Registered Nurse (RN) stated that the resident's Substitute Decision Maker (SDM) requested that the resident be taken to the dining room during mealtime. This intervention was part of the resident's written plan of care.

During an observation, the resident was not taken to the dining room during lunch.

Personal Support Worker (PSW) acknowledged that the resident was not taken to the dining room as per the plan of care. Nurse Manager (NM) confirmed that the staff were expected to follow the resident's plan of care.

There was low risk for the resident when the resident's nutrition care was not consistent with their needs.

Sources: Resident’s written plan of care and care records, observation, interviews with RN, PSW and NM.

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[739633]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 fall prevention interventions were provided to a resident as specified in their plan of care.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director related to the resident's fall which resulted in an injury for which they were taken to the hospital.

The care plan of the resident stated that they required a specific fall intervention. The Registered Practical Nurse (RPN) stated that they found the resident lying on the floor without the specific intervention in place. The RPN demonstrated what they had observed at the time of the fall incident using the resident's specific equipment. This revealed that the specific intervention was not in place as specified in the resident's care plan.

There was an increased risk for injury when the resident fell without having intervention in place.

Sources: Observation of resident' personal equipment, CIS, resident's care plan, and interview with RPN.

[000715]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure suspected improper or incompetent treatment or care of a resident was immediately reported to the Director.

Rationale and Summary
The resident experienced a change in their health status on a specified date. The PSW reported it to the RN twice, however they failed to assess the resident and provide treatment. In addition, The RN also failed to inform the oncoming staff.

The NM interviewed the RN during the home's investigation and identified they did not assess, document, provide treatment to the resident and communicate to oncoming staff. The NM confirmed that they missed submitting a CI report to inform the Director regarding the suspected improper or incompetent care of the resident.

Sources: CIS, and interviews with PSW, RN and NM.

[000715]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that residents #002 and #004 received skin assessments by a registered staff when they exhibited altered skin integrity.

Rationale and Summary
(i) Resident #004 had a skin alteration, and a staff member reported it to the registered staff on an identified date. Later, the resident’s skin alteration worsened as per an assessment.

The home’s skin and wound care program policy directed staff to assess all residents exhibiting altered skin integrity upon initial discovery and use specific skin integrity assessment tools for reddened areas.

The RN acknowledged that a skin assessment was not completed after the skin alteration was reported to them. NM and Director of Care (DOC) verified that a skin assessment was expected to be completed when the skin alteration was initially reported.

There was a risk of not receiving appropriate treatment and interventions when a skin assessment was not completed upon the initial discovery of the resident’s skin impairment.

Sources: The home’s policy, Skin and Wound Program: Wound Care Management (RC-23-01-02, Last Reviewed March 2023), resident’s progress notes and clinical records, interviews with RN, NM and DOC.

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(ii) Upon readmission from the hospital, the resident's head to toe assessment revealed that they had skin alterations on identified body areas as well as an injury. There was no skin and wound assessment

completed using the home's clinically appropriate tool after the skin alteration was identified. The RPN confirmed that the skin and wound assessment tool had not been completed.

The resident reported pain during an interview with the inspector. On observation, the resident had skin alterations on identified body areas with injury. The resident and private caregiver explained the pain, skin alteration and injury were not new, and most likely worsened when staff repositioned the resident in bed and performed personal care. After RPN was informed of the resident's condition by the inspector, they stated they had not previously seen the skin alteration and injury and would follow up with the pain complaint as well.

The following day, the clinical records showed there was no skin and wound assessment completed for the skin alteration and injury. The RPN who was regularly assigned to the resident shared that they were aware of the injury which had been ongoing. In addition, the resident's care plan and Treatment Administration Record (TAR) had no interventions for the resident's skin condition.

The NM stated that a skin and wound assessment should have been initiated including a picture of the affected areas. They noted that further investigation to determine cause, a skin treatment care plan, and pain management interventions should have also been initiated as per the home's policy.

When the resident's skin condition was not assessed using a clinically appropriate assessment tool, there was increased risk of inadequate skin treatment and poor pain management.

Sources: Observation of resident, CIS, Skin and Wound Policy RC-19-01-0, last reviewed March 2023, resident's care plan, TAR for July 2023, clinical assessment page, head to toe assessment, and interviews with resident, private caregiver, RPNs and NM.

[000715]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that resident #002's, resident #004’s and resident #005's skin alterations were reassessed weekly by registered nursing staff.

Rationale and Summary
(i) Resident #002's hospital readmission head to toe assessment revealed that they had skin alterations. There were no weekly skin assessments documented for a specified period. The RPN confirmed that the skin and wound assessment tool had not been completed weekly as per the home's policy.

Resident #002 had a skin alteration discovered on an identified date, when they reported pain to specified body parts during an interview. Resident #002 and private caregiver noted the skin alteration was not new.

The NM acknowledged that there were gaps in assessment following the initial discovery of skin alterations. They stated that there should have been a skin and wound assessment initiated, a skin treatment plan, pain monitoring and a weekly skin assessment as per the home's policy. The home was unable to verify if one of the skin alterations was the same one previously discovered on an identified date, or if it was a new skin condition.

There was increased risk of inadequate skin monitoring and treatment when weekly skin assessments were not completed.

Sources: Observation of resident #002, CIS, clinical assessment page, head to toe assessment, and interviews with resident #002, private caregiver, RPN, and NM.

[000715]

(ii) Resident #004 had developed a skin alteration according to an assessment completed on an identified date, which had not healed at the time of the inspection.

No re-assessments were completed of the skin alteration for a specific period of time. The NM acknowledged that the wound was not re-assessed during these weeks. The DOC stated that staff were expected to re-assess the wound weekly.

There was a risk of not evaluating the state of the wound and required treatments when the weekly wound assessments were not completed.

Sources: The home’s policy, Skin and Wound Program: Wound Care Management (RC-23-01-02, Last Reviewed March 2023), resident’s progress notes and clinical records, interviews with NM and DOC.

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(iii) Resident #005 sustained a skin alteration. The resident had initial skin and wound assessment completed by the registered staff, however there were no weekly skin and wound assessments completed for two weeks.

The NM and RPN, both stated that resident #005's skin alteration should have been assessed weekly using the skin and wound care application and weekly assessments were not completed.

There was an increased risk that resident #005 wound would worsen in the absence of weekly assessments since the effectiveness of the wound care was not being evaluated.

Sources: Skin and Wound Policy RC-19-01-0, last reviewed March 2023, resident #005's progress notes, care plan, interviews with RPN and NM.

[741673]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)

The licensee has failed to ensure that the resident was assessed by Registered Dietitian (RD) when they had developed wounds.

Rationale and Summary
The resident developed wounds according to assessments completed on specified dates.

The NM acknowledged that no referrals were sent to the RD for assessing the resident's nutritional requirements in relation to wounds. The NM and DOC confirmed that the RD should have assessed the resident after the wounds developed.

There was a risk of nutritional interventions not being developed and implemented when the RD did not assess the resident.

Sources: The home's policy, Skin and Wound Program: Wound Care Management (RC-23-01-02, last reviewed March 2023), resident's progress notes and clinical records, interviews with NM and the DOC.

[739633]

WRITTEN NOTIFICATION: Pain Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

The licensee has failed to comply with strategies to manage the pain of a resident when they reported pain to a specified body part.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management program, at a minimum, provides for strategies to manage pain for residents and must be complied with. Specifically, the staff did not comply with the home's pain management policy and procedure.

Rationale and Summary
The home's Pain Identification and Management policy directed nurses to complete comprehensive pain assessments for new pain, then use the assessment to develop the plan of care and make referrals to other health professionals, as appropriate. The policy also stated to communicate at every shift at shift report any residents with new and/or unresolved pain management issues.

On an identified date, the resident experienced pain, and a change in health status. PSW informed The RN when they discovered the resident in pain, and a second time towards the end of the shift. However, the RN did not attend to resident to complete an assessment or provide interventions to manage the pain throughout the night shift.

The oncoming shift was unaware of the resident's pain and change in health status. The RPN stated that when they received shift report, the RN failed to relay this information. On an identified date, during morning care, the resident complained of pain and had difficulty ambulating, and PSW reported it to the RPN. The NM acknowledged that RN failed to assess and treat the resident's pain, and they also failed to collaborate with the oncoming shift. The resident had sustained an injury and was transferred to the hospital.

When the resident's pain was not assessed as per home's policy and pain management strategies were not implemented during the shift, it led to further discomfort, difficulty ambulating and risk of further aggravating their injury.

Sources: CIS, Pain Identification and Management RC-19-01-0, last reviewed March 2023, clinical assessment page, resident's progress notes, care plan, and interviews with PSWs, RPN, RN, and NM.

[000715]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that symptoms indicating the presence of infection for the resident were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections (HAIs).

Rational and Summary
The home received a complaint from the resident's Power of Attorney (POA) regarding a change in resident's health status.

The resident was assessed by the Nurse Practitioner (NP) on the same day and was prescribed with a medication until improved. The resident was also assessed by in-house Medical Doctor (MD) and was prescribed another medication. On an identified date, the resident was again assessed by in-house MD and was prescribed medication for an infection.

There was no evidence that the resident's infection was being monitored on every shift, nor that the effectiveness of the medication was being evaluated.

The RPN verified that when a resident has symptoms of an infection, staff were to monitor the resident, and document the symptoms in a progress note on every shift. The RPN and NM both acknowledged that the resident's symptoms were not monitored and documented on every shift during the time that the resident had an infection.

The resident was at risk for discomfort when the resident's infection was not monitored on every shift and the effectiveness of the medication was not being evaluated.

Sources: Resident's progress notes and care plan, interviews with RPN and NM.

[741673]