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: September 29, 2023	
Inspection Number: 2023-1514-0007	
Inspection Type: Critical Incident	
Licensee: Villa Colombo Homes for the Aged Inc.	
Long Term Care Home and City: Villa Colombo Homes for the Aged, Toronto	
Lead Inspector Britney Bartley (732787)	**Inspector Digital Signature** Britney Bartley Digitally signed by Britney Bartley Date: 2023.10.04 12:52:26 -04'00'
Additional Inspector(s) Lisa Salonen Mackay (000761)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29-31, 2023, and September 1, 5-8, 11, 12, 2023.

The following intake(s) were inspected:

- Intake: #00092954 – A resident missing for more than 3 hours.
- Intake: #00093607 – A resident sustained a fracture of unknown cause.
- Intake: #00094734 – Fall of a resident resulting in fracture.
- Intake: #00094758 – Respiratory Outbreak.
- Intake: #00094806 – Unexpected death of a resident.

The following intakes were completed in this inspection: Intakes: #00094216, #00093090, #00093121, #00093178, #00092088, #00092171 and #00092596 were related to falls prevention and management.

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

Resident Care and Support Services
Safe and Secure Home
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 (2) (b)

The licensee has failed to implement a protocol issued by the Director with respect to infection prevention and control.

The license has failed to ensure that the required personal protective equipment (PPE) was used in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) as required by Additional Requirements 9.1(d) under the IPAC Standard.

Rationale and Summary

A resident who was positive for COVID – 19, signage at their room entrance indicated they were on additional precautions. A visitor was observed in the resident's room not wearing the required PPE. The IPAC Lead confirmed there was miscommunication on which PPE visitors were to apply, and a nurse provided education to the visitor. The following day, the visitor was observed in the resident's room without wearing the required PPE.

The IPAC Lead acknowledged that when in a resident's room who was on additional precautions all visitors were expected to wear the required PPE.

Failure to follow posted signage at resident's room entrance increases the risk of infection transmission.

Sources: Observations, review of IPAC Standard and interview with IPAC Lead.

[000761]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that the IPAC lead carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that there was in place a hand hygiene program in accordance with the IPAC Standard for Long Term Care Homes April 2022. Specifically, the IPAC lead did not ensure that hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR) was easily accessible at point-of care, and any staff providing direct resident care had immediate access to 70-90% ABHR as required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary

On September 5, 2023, six wall mounted hand sanitizers were observed missing on a resident's home area. One of the missing hand sanitizers was beside the soiled utility room. A Housekeeper indicated there was a bottle hand sanitizer at the nursing station located across the soiled utility room and noted staff were to use that as an alternate option. At the time of the observation there was no bottle hand sanitizer at the nursing station.

A Registered Practical Nurse (RPN) and a Housekeeper both acknowledged that there were missing wall mounted hand sanitizer on the unit and unclear how long it had been broken.

Maintenance lead stated a work order was received on September 6, 2023, to replace the six missing wall mounted sanitizers on the third floor.

Failure to provide easily accessible 70-90% ABHR hand hygiene agents put residents at increased risk of infection.

Sources: Review of IPAC Standard, Hand Hygiene Policy IX-G-10.10, observations, interviews with Housekeeper, RPN and Maintenance Lead.

[000761]

COMPLIANCE ORDER CO #001 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

The licensee shall:

1. Re-train a Personal Support Worker (PSW) on assistance requirements in a resident's care plan.

2. Maintain a record of the above training, including the date, content, who facilitated the education, and signed staff attendance.

3. Conduct random audits, for a minimum of three weeks following service of this order, of a resident's safety device to ensure it is in working order and in use when the resident is in bed.

4. Maintain a record of audits conducted, to include, but not limited to: audit dates, person(s) completing the audits, audit findings and any actions taken in response to the audit findings.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to residents #003 and #004.

Rationale and Summary

1) A Critical Incident (CI) report was submitted to the Director related to a resident's unknown cause of injury and subsequent transfer to hospital.

The resident's care plan indicated they required a specific intervention to assist them, this was implemented since the resident's admission.

A PSW indicated they assisted the resident and did not follow the specific intervention, after assisting the resident, the resident complained of pain. Upon assessing, redness and swelling was noted on the resident's body. The PSW indicated that they were told the resident required a different assistance and had been assisting the resident that way since admission.

Physiotherapist (PT) confirmed that the resident required a specific assistance. The PT also indicated that staff were not allowed to downgrade the resident's assistance status.

Nurse Manager (NM) indicated during the home's investigation the PSW acknowledged that they did not follow the specific assistance intervention, and suggested another intervention was sufficient for the resident. A re-assessment was completed by the PT, who concluded that the original assistance intervention should be followed.

Staff failure to follow the resident's care plan and provide the required assistance put them at risk for injury.

Sources: Review of a resident's clinical records, interviews with NM, PT and a PSW.

[732787]

Rational and Summary

2) A CI report was submitted to the Director related to a resident's fall with injury and subsequent transfer to hospital.

A resident's care plan under falls prevention directed staff to ensure that the safety device was properly applied and in use when the resident was in bed.

A PSW indicated that the resident's safety device had been applied on the bed but was not working at the time of the resident's fall. They could not recall when the safety device had stopped working.

A Registered Practical Nurse (RPN) indicated that the safety device was not on the bed at the time of the resident's fall and was only implemented after they fell.

In review of the CI, it stated that the resident's safety device was implemented after the fall. The CI was completed by NM, who indicated that they were not aware that the safety device was in the resident's plan of care prior to their fall, and stated it should have been applied as per care plan.

Failure to ensure that the safety device was in working condition at the time of the fall put the resident at risk of not having it being heard by staff.

Sources: Review of a resident's clinical records, interviews with NM, RN, RPN and a PSW.

[732787]

This order must be complied with by October 31, 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.