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: November 6, 2023	
Inspection Number: 2023-1514-0008	
Inspection Type: Proactive Compliance Inspection	
Licensee: Villa Colombo Homes for the Aged Inc.	
Long Term Care Home and City: Villa Colombo Homes for the Aged, Toronto	
Lead Inspector Henry Chong (740836)	**Inspector Digital Signature** Henry A Chong Digitally signed by Henry A Chong Date: 2023.11.09 09:38:31 -05'00'
Additional Inspector(s) Noreen Frederick (704758)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10, 12, 13, 16-20, 23-25, 2023

The following intake(s) were inspected:

- Intake: #00098748 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
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, 2021, s. 6 (7)

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

Rationale and Summary
The resident's care plan indicated that they required interventions for toileting, transfers and bathing.

Personal Support Worker (PSW) #114 stated that they did not follow the interventions in place for the resident on an identified date. Nurse Manager #113 acknowledged that the staff was expected to provide care to the resident as indicated in their care plan.

Failure to ensure that the resident was provided with care as set out in their care plan, placed the resident at risk for a potential injury.

Sources: resident's care plan, and interviews with PSW #114 and Nurse Manager #113.

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WRITTEN NOTIFICATION: Windows

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents had a screen and cannot be opened more than 15 centimeters.

Rationale and Summary
During a tour of the home with the Maintenance Aide #100, they measured the window opening in a

resident's room to be 17.14 centimeters (cm).

Maintenance Aide #100 and Assistant Executive Director #112 both acknowledged that each window should not open more than 15cm.

Window opening in resident's room exceeding the required opening of 15cm puts the resident at risk for elopement.

Sources: inspector's observation, and interview with Assistant Executive Director.

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WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that uses sound which was properly calibrated so that the level of sound was audible to staff.

Rationale and Summary
During a tour of the home, five call bells were checked with Personal Support Workers (PSW) #101, #102 and RPN #103 and were not audible and did not display the room number on the panel in the hallway. The long-term care home (LTCH) completed preventative maintenance audits in August 2023.

The Director of Care (DOC) acknowledged that the call bells needed to be functional at all times and the staff were expected to report immediately of any malfunction of call bells.

Failure of the audible sound from the call bell system in the residents' rooms posed an increased risk to the residents' safety.

Sources: inspector's observations and interview with DOC.

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WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 3.

The licensee has failed to ensure that a continence care and bowel management program to promote continence was implemented.

In accordance with O. Reg 246/22, 11 (1) (b), the licensee was required to ensure a continence care and bowel management program to promote continence was implemented and was complied with.

Specifically, the Long-Term Care home (LTCH) did not comply with their policy "Continence Management Program" RC-14-01-01, last reviewed date March 2023.

Rationale and Summary
The LTCH's continence management policy required a nurse to complete a continence assessment using a clinically appropriate assessment tool that was specially designed for assessing continence upon admission for all residents. Nurse Manager #119 stated that according to their audit, numerous new resident admission continence assessments were missed for a specified period of time.

Failure to complete a continence admission assessment, increased the risk of residents not receiving interventions to promote continence, maximize residents' independence, comfort and dignity.

Sources: LTCH's "Continence Management" policy #RC-14-01-01, last updated March 2023, Nurse Manager #119's continence assessment audit, and interview with Nurse Manager #119.

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WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee has failed to ensure that when resident #001 and resident #002 had a specific continence status, they received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition

or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of the continence status.

Rationale and Summary
a) Resident #001's bladder and bowel continence assessment indicated a specific status when completed upon admission. The resident's current care plan recorded a change to their bowel function status. A clinical record review showed that the resident did not receive an appropriate assessment. Home's Continence Management Policy RECI-10-04-01 last updated November 2013 required staff to complete an assessment using a clinically appropriate assessment tool with any changes in continence level.

Nurse Manager #119 stated that staff were expected to complete an assessment when the resident's continence level changed.

The lack of a continence assessment for resident #001 placed them at risk for not receiving the interventions to promote and manage bowel continence.

Sources: resident #001's record review, LTCH's "Continence Management" policy #RECI-10-04-01, last updated November 2013, and interview with Nurse Manager #119.

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Rationale and Summary
b) Resident #002's bladder and bowel continence assessment indicated a specific status when completed upon admission. The resident's current care plan recorded a change to their bladder function status. A clinical record review showed that the resident did not receive an appropriate assessment. Home's Continence Management Policy RC-14-01-01 last updated February 2017 required staff to complete a continence assessment using a clinically appropriate assessment tool with any changes in continence level.

Nurse Manager #119 stated that staff were expected to complete an assessment when the resident's continence level changed.

The lack of a continence assessment for resident #002 placed them at risk for not receiving the interventions to promote and manage bowel continence.

Sources: resident #002's record review, LTCH's "Continence Management" policy #RC-14-01-01, last updated February 2017 and interview with Nurse Manager #119.

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WRITTEN NOTIFICATION: Infection prevention and control program

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 the infection prevention and control (IPAC) standard issued by the Director was followed as it relates to hand hygiene practices.

Rationale and Summary
During observations conducted in the home, Registered Practical Nurse (RPN) #108 was observed not performing hand hygiene before and after coming into contact with several residents.

According to the resident's policy "Hand Hygiene, IC-02-01-08", staff were required to perform hand hygiene before and after contact with the residents.

The Infection Prevention and Control (IPAC) Lead #106 stated that staff was required to perform hand hygiene before and after each resident contact.

Not adhering to hand hygiene best practices placed residents at risk of contracting infectious diseases.

Sources: observations, Licensee's policy Hand Hygiene, IC-02-01-08 last reviewed on January 2023, and interview with the IPAC Lead.

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WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

The licensee has failed to ensure their continuous quality improvement (CQI) committee was composed of pharmacy service provider, a personal support worker, one member of the home's Residents' Council, and one member of the homes Family Council.

Rationale and Summary
The home's CQI committee had not included the following required roles: the home's pharmacy service provider, a personal support worker, one member of the home's Residents' Council and one member of the home's Family Council.

The Director, Resident Services acknowledged that the home's CQI committee did not include the required members.

Failure to include the required roles in the CQI committee may result in potential interdisciplinary feedback not being included to assist the home in their CQI initiatives.

Sources: CQI committee agenda and members list; and interview with the Director, Resident Services.

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WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)

The licensee has failed to ensure that a copy of the CQI initiative report was provided to the Residents' Council.

Rationale and Summary
The home's CQI initiative report was not provided to the Residents' Council.

A review of the home's Resident Council Meeting Minutes did not include updates related to the CQI initiative report.

The Director, Resident Services said that the CQI initiative report was not provided to Residents' Council.

Failure to provide the home's CQI initiative report may result in residents not being aware of the status of the home's CQI initiatives.

Sources: Resident Council Meeting Minutes; and interview with Director, Resident Services.

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WRITTEN NOTIFICATION: Orientation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act, included all eight required topics.

Rationale and Summary
IPAC training records were reviewed for two newly hired staff and it did not include the training on signs and symptoms of infectious diseases. IPAC Lead #106 acknowledged that training on signs and symptoms of infectious diseases was not completed for all newly hired staff.

Failure of the home to ensure that newly hired staff completed IPAC training in signs and symptoms of infectious diseases increased the risk of new staff not following IPAC practices.

Sources: training records for newly hired staff, and interviews with IPAC lead and other staff.

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WRITTEN NOTIFICATION: Orientation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act, included all eight required topics.

Rationale and Summary
IPAC training records were reviewed for two newly hired staff and it did not include the training on respiratory etiquette. IPAC lead #106 acknowledged that training on respiratory etiquette was not completed.

Failure of the home to ensure that newly hired staff completed IPAC training in respiratory etiquette increased the risk of new staff not following IPAC practices.

Sources: training records for newly hired staff, and interviews with IPAC lead and other staff.

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WRITTEN NOTIFICATION: Orientation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act, included all eight required topics.

Rationale and Summary
IPAC training records were reviewed for two newly hired staff and it did not include the training on what to do if experiencing symptoms of infectious disease. IPAC lead #106 acknowledged that training on what to do if experiencing symptoms of infectious disease was not completed.

Failure of the home to ensure that newly hired staff completed IPAC training in what to do if experiencing symptoms of infectious disease increased the risk of new staff not following IPAC practices.

Sources: training records for newly hired staff, and interviews with IPAC lead and other staff.

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WRITTEN NOTIFICATION: Orientation

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act, included all eight required topics.

Rationale and Summary
IPAC training records were reviewed for two newly hired staff and it did not include the training on handling and disposing of biological and clinical waste. IPAC lead #106 acknowledged that training on handling and disposing of biological and clinical waste was not completed.

Failure of the home to ensure that newly hired staff completed IPAC training in handling and disposing of biological and clinical waste increased the risk of new staff not following IPAC practices.

Sources: training records for newly hired staff, and interviews with IPAC lead and other staff.

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