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: December 22, 2023	
Inspection Number: 2023-1514-0010	
Inspection Type: Complaint 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 Joy Ieraci (665)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12, 13, 14, 18, 19, 2023

The inspection occurred offsite on the following date(s): December 20, 2023

The following intake(s) were inspected:

- Intake: #00102539/Critical Incident System (CIS) related to a fall with injury and;
- Intake: #00102386/Complaint related to an allegation of abuse and skin and wound.

The following intake(s) were inspected:

- Intake: #00101337/CIS and;
- Intake: #00103418/CIS, both related to falls.

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

- Skin and Wound Prevention and Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- 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 (4) (b)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the implementation of the plan of care so that different aspects of care were integrated and were conistent with and complemented each other related to falls.

Rationale and Summary

A resident had a fall and sustained an injury. They were at risk for falls and had a history of falls. At the time of the fall, the resident's plan of care had an intervention

to ensure their safety. The Personal Support Workers' (PSWs) documentation indicated that the intervention was not implemented.

A PSW stated they were not aware of the intervention at the time of the fall, as it was not included in the resident's Kardex. They indicated that the resident required the intervention.

A Registered Practical Nurse (RPN) indicated that the intervention was not included as a task in the plan of care for PSWs to implement.

Failure of the staff to collaborate in the implementation of the resident's falls intervention had put the resident at risk of further injury in the management of their falls.

Sources: Review of CIS report, a resident's assessments, care plan, kardex, progress notes, and documentation survey report, and interviews with a PSW, RPN and other staff. [665]

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)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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 related to responsive behaviours.

Rationale and Summary

The resident had a history of physically responsive behaviours towards co-residents. The plan of care had two interventions to manage their responsive behaviours. On two separate observations, the interventions were not in place.

An RPN indicated the resident required the interventions to manage their responsive behaviours towards co-residents.

Failure to follow the resident's plan of care had put the resident and co-residents at risk of harm.

Sources: Observations on two separate dates, review of a resident's plan of care, and interviews with an RPN and other staff. [665]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

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

Rationale and Summary

The home received a written complaint regarding an allegation of abuse towards a resident.

The Director of Resident Services (DNS) acknowledged that the written complaint was not forwarded to the Director..

There was no risk to the resident, however, the home's management of their complaints procedures may not be as effective.

Sources: Review of the written complaint, and interviews with the DNS and other staff. [665]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a PSW and a Registered Nurse (RN) who had reasonable grounds to suspect that abuse to a resident had occurred by anyone, immediately reported the suspicion and the information upon which it was based to the Director.

In accordance with FLTCA, 2021, s. 154 (3), the licensee was vicariously liable when the the staff members had not complied with subsection 28 (1).

Rationale and Summary

The resident was found to have an injury and was transferred to hospital.

The PSW found the resident with an injury. The resident told the PSW that they had an altercation with a co-resident.

The resident returned from hospital and told the RN about their allegation of abuse.

Both staff did not report the allegation of abuse to the Director.

Failure to report the resident's allegation of abuse to the Director, prevented the home to investigate, respond and act on the allegation.

Sources: Review of a resident's progress notes and interviews with a PSW, RN and other staff. [665]

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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)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

The resident had an area of altered skin integrity. Weekly skin and wound assessments were not completed.

An RPN and the DRS acknowledged that that the weekly assessments were not completed.

The resident's area of altered skin integrity may not have been monitored effectively to promote healing when weekly skin and wound assessments were not completed.

Sources: Review of a resident's clinical records and interviews with an RPN, DRS and other staff. [665]