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: December 14, 2023

Inspection Number: 2023-1514-0009

Inspection Type:
Complaint
Critical Incident
Follow up

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**
Noreen Frederick (704758)	Noreen Frederick Digitally signed by Noreen Frederick Date: 2024.01.03 15:44:03 -05'00'

Additional Inspector(s)
Chinonye Nwankpa (000715)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 10, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 2023

The following intake(s) were inspected:

- Intake: #00098251 - Follow-up-Plan of Care
- Intake: #00095790 -[Critical Incident (CI): 3020-000100-23] and Intake: #00096393 - [CI: 3020-000101-23]-Fall resulting in an injury
- Intake: #00099121 - [CI: 3020-000108-23]-COVID-19 outbreak
- Intake: #00100014 - [CI: 3020-000110-23]-Improper positioning
- Intake: #00096884 - Complaint related to staff, nutrition, hydration, personal

care, medication and pharmacy billing

The following intakes were completed in this inspection: Intake #00098307, CI #3020-000105-23, Intake #00101316, CI #3020-000114-23, Intake #00096938, CI #3020-000103-23, Intake #00100815, CI #3020-000113-23, and Intake #00101676, CI #3020-000119-23 were related to respiratory outbreaks.

Intake #00095770, CI #3020-000099-23, Intake #00098918, CI #3020-000106-23, and Intake #00100178, CI #3020-000111-23 were related to falls.

Intake #00101653, CI #3020-000120-23 was related to unknown etiology fracture.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1514-0007 related to FLTCA, 2021, s. 6 (7) inspected by Chinonye Nwankpa (000715)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, 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
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 failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care following resident #001's discharge from the hospital, and for resident #005 related to a medication order.

Rationale and Summary
(i) A resident returned to the home with a diagnosis of an injury from a fall incident. The hospital records showed the discharging physician directed for the home to hold one of the resident's medications for several days.

The resident's chart revealed the medication reconciliation was completed; however, the medication was not put on hold. The Electronic Medication Administration Record (EMAR) showed the resident was administered this medication daily.

The Registered Practical Nurse (RPN) acknowledged the direction to hold the

medication was not transcribed and communicated to the Physician and as a result, the medication was administered to the resident. The Nurse Manager confirmed the medication should have been put on hold and the staff failed to collaborate to update the resident's medical plan.

There was risk of further injury when the staff failed to collaborate and communicate the changes in the resident's plan of care.

Sources: Resident's hospital records, medical chart, progress notes, EMAR, and Interviews with RPN and Nurse Manager.

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(ii) The Substitute Decision Maker (SDM) of a resident stated that they did not want a specific medication everyday as they were concerned about the side effects of the medication. An RPN obtained a medication order. The physician stated that they were not informed about SDM not wanting the medication. The EMAR indicated that the medication was administered to the resident at a specific interval.

The Nurse Manager acknowledged that the staff were expected to collaborate with each other to ensure that the order was obtained according to the SDM's consent.

The staff's failure to collaborate with each other put the resident at risk of not receiving treatment as consented by the SDM.

Sources: Resident's clinical records, and interviews with RPN, Physician, Nurse Manager and other staff.

[704758]

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)

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 resident #001's plan of care was provided as specified in the plan pertaining to their communication device placement, and resident #004's assistive aide and positioning.

Rationale and Summary
(i) A Critical Incident System (CIS) report was submitted to the Director for a resident who sustained a fall that resulted in an injury.

The resident was found on the floor, following which they were sent to the hospital and diagnosed with an injury. Their care plan stated a communication device to was be applied to the resident when in bed.

Personal Support Workers (PSW) #112 and #113 relayed the communication device had not been applied on the resident when they were in bed prior to their fall. An RPN confirmed when they discovered the resident that the communication device was not heard.

The Behaviour Support Ontario (BSO) Lead acknowledged the staff failed to apply the communication device to the resident.

When the communication device was not on the resident, there was risk of delayed response and treatment as staff were not alerted immediately when they fell out of bed.

Sources: Resident's clinical records, interviews with PSW #112, PSW #113, RPN and BSO Lead.

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(ii) On a specified date, a resident was observed seated in a specific position on their assistive device in their room. The care plan directed the staff to position the resident in a specified manner for their safety.

The PSW confirmed that the resident had not been placed in a specified position as per their care plan. The Nurse Manager and the BSO Lead acknowledged staff were supposed to ensure the assistive device was positioned as per their care plan because of the resident's medical condition, but this was not being done.

There was risk to the resident when the staff failed to position their assistive device as indicated in their care plan.

Sources: Observation, resident's care plan, interviews with PSW, Nurse Manager and BSO Lead.

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(iii) A resident was observed without their assistive aides on a specified date. The care plan directed the staff to apply the assistive aide on the resident on a specified time.

The PSW confirmed that the resident did not have their assistive aide applied. The RPN stated the assistive aide was not applied as directed in the care plan.

Failing to apply the resident's assistive aide put them at risk of experiencing communication difficulties.

Sources: Observation, resident's clinical records, and interviews with PSW and RPN.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the plan of care was reviewed and revised when residents #001 and #004's care needs changed and when care set out in the plan was no longer necessary.

Rationale and Summary
(i) On a specified date, a resident was observed in an assistive device, however no fall prevention intervention was seen on the assistive device.

The resident 's care plan indicated they required staff to apply a fall prevention intervention when the resident was on their assistive device. The care plan also stated the resident did not require a mobility device due to a specified reason.

The PSW and the BSO Lead confirmed that the resident once had an assistive device and the fall intervention, but no longer required it.

There was risk of the resident being provided the incorrect intervention when staff failed to update the resident 's care plan.

Sources: Observation, resident's care plan, and interviews with PSW and BSO Lead.

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(ii) A resident sustained a fall and following the fall incident, a fall intervention strategy was initiated as noted in the CIS report.

Upon review of the resident's care plan and other clinical records, this intervention was not documented.

PSWs #112 and #113 confirmed that after the fall incident, the fall intervention was initiated. The BSO Lead acknowledged the resident's care plan had not been updated post-fall to include the new fall intervention.

There was risk a risk of the resident not receiving the fall intervention when staff failed to update the resident's care plan.

Sources: CI #3020-000101-23, resident's clinical records, interviews with PSW

#112, PSW #113 and BSO Lead.

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(iii) On two specified dates, a resident did not receive assistance with their Activities of Daily Living (ADLs). The resident required assistance to maintain their care . However, their ADL plan was not updated in the resident's care plan.

The PSW explained that the resident was to be provided assistance with ADLs but this was not updated in their care plan. The PSW did not provide assistance and acknowledged the resident's care plan had not been updated to reflect the ADL frequency.

The Nurse Manager confirmed that the resident was supposed to receive assistance with ADLs as agreed with the resident's SDM. The BSO Lead verified that the care plan had not been updated with the resident's ADL plan.

When the resident's ADL plan was not updated in their care plan, there was increased risk of staff not providing assistance when required.

Sources: Resident's care plan, and interviews with PSW #117, PSW #119, BSO Lead and Nurse Manager.

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(iv) On an identified date, a resident was observed alone in their bedroom seated in their assistive device. The resident's care plan stated for the resident to be placed outside of their room when there was no caregiver present.

The PSW relayed that staff were permitted to leave the resident in their room on their assistive device. The Nurse Manager and the BSO Lead both verified the family preferred the resident in their room due their safety. However, the care plan had not been updated to reflect this change.

There was risk to the resident when their care plan was not updated to reflect their current preferences and needs.

Sources: Resident's care plan, and interviews with PSW, BSO Lead and Nurse Manager.

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(v) A resident's care plan directed staff to rotate their equipment every few hours from a regular equipment to their assistive device for specified reasons.

The Occupational Therapist (OT) stated the resident had been assessed to use a specific assistive device, and as such should not be seated in another equipment. The Nurse Manager acknowledged the resident was not being repositioned from the regular equipment to their assistive device, as this intervention was no longer required. However, this was not updated in their plan of care.

There was risk to the resident when staff failed to revise the residents care plan when the above mentioned intervention was no longer required.

Sources: Resident's care plan, and interviews with OT, and Nurse Manager.

[000715]

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.

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 an alleged incident of neglect was immediately reported to the Director.

Rationale and Summary
The home submitted a written complaint to the Director days after the home had initially received the complaint. The complainant alleged they witnessed the neglect of a resident's roommate.

The BSO Lead who submitted the written complaint verified that they failed to report the allegation of neglect immediately to the Director.

Sources: CI report #3020-000110-23, written complaint, interview with BSO Lead.

[000715]

WRITTEN NOTIFICATION: FALL PREVENTION AND

MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

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

Rationale and Summary
The home's Fall Management policy stated following a fall incident, the registered staff were to complete an incident report, post-fall assessment and post-fall team huddle.

The resident's progress note showed they sustained a fall and upon review of their clinical records, there was no post-fall assessment documented using the home's assessment tools specifically designed for falls.

The BSO Lead acknowledged the home's post-fall assessments and risk management incident report were not completed by the staff and as a result, the resident's plan of care had not been updated.

When staff failed to complete the post fall assessments, it increased the risk of inadequate post-fall analysis and not putting fall preventative strategies in place.

Sources: Resident's clinical records, and interview with BSO Lead.

[000715]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance occurred in the home, specifically COVID-19 outbreaks.

Rationale and Summary
A CIS report 3020-000108-23 was submitted to the Director and indicated that public health declared a COVID-19 outbreak on October 7, 2023. The report was submitted on October 10, 2023.

The Infection Prevention and Control (IPAC) Lead stated that they were aware of reporting guidelines related to outbreak of a disease.

Failure to submit CIS report within the appropriate timeline may have resulted in the Director being unaware of the outbreak and taking necessary actions.

Sources: CIS #3020-000108-23 and interview with IPAC Lead.

[704758]

WRITTEN NOTIFICATION: System for notifying pharmacy service provider

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 130

s. 130. Every licensee of a long-term care home shall ensure that a system is developed for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident.

The licensee has failed to ensure that a system was developed for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident.

In accordance with O. Reg. 246/22 s 11 (1) (b), the licensee was required to inform the pharmacy immediately if medications were received after a resident was deceased. Specifically, staff did not comply with home's policies and procedures: Manual for MediSystem Serviced Homes "If medications were received for a discharged/deceased resident in the next weekly delivery, please call pharmacy immediately to inform them of the discharged or deceased resident".

Rationale and Summary
A resident deceased and the home continued to receive the resident's medication for a specified period. The Lead Pharmacist stated that they were never informed by the home of the resident's discharge. The Nurse Manager stated that staff were expected to call the pharmacy to notify of the resident's discharge every week when they received the resident's medication.

Failure to notify the pharmacy of resident's discharge led to the home obtaining medication which was not based on a resident usage.

Sources: The home's policies and procedures: Manual for MediSystem Serviced Homes (pg. 15), Medisystem shipping slips, and Interview with Lead pharmacist, and Nurse Mange.

[704758]

WRITTEN NOTIFICATION: Drug record (ordering and receiving)

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 145

s. 145. Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

The licensee has failed to ensure that a drug record for a resident, was established, maintained and kept in the home for at least two years, in which was recorded the following information, in respect of every drug that was ordered and received in the

home:

1. The date the drug was ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 148 (4).

Rationale and Summary
A review of drug record revealed that a resident's drug record related to a specific medication reorder from 2022 was missing. The Nurse Manager stated that they could not find the 2022 drug record.

Failure to maintain the drug record for at least two years increases the risk of inaccurate medication histories which may contribute to prescription errors.

Sources: Interview with Nurse Manager .

[704758]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (3) (b) (ii)

s. 148 (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(ii) one other staff member appointed by the Director of Nursing and Personal Care.
O. Reg. 246/22, s. 148 (3); O. Reg. 66/23, s. 31.

The licensee has failed to ensure that drugs were destroyed by a team acting together composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care.

Rationale and Summary
The RPN and the Registered Nurse (RN) both stated that non-controlled medications were removed from the medication cart and put into the medical waste container located in the medication room. The Nurse Manager stated that non-controlled medications were destroyed by a single nurse with no documentation. A review of the home's policies and procedures manual for MediSystem serviced homes specified " In Ontario, documentation of each sealed container must be recorded on the Non-Narcotic and Non-Controlled Drugs for Destruction Record".

Failure to complete non-controlled drug destruction by a team acting together, there was a potential risk of unsafe medication disposal.

Sources: Interviews with RPN, RN and Nurse Manager and the home's policies and procedures manual for MediSystem serviced homes, pg. 46.

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WRITTEN NOTIFICATION: Drug destruction and disposal

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (5) (a)

s. 148 (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective;

The licensee has failed to ensure that the drug destruction and disposal system was audited at least annually to verify that the licensee's procedures were being followed and were effective.

Rationale and Summary
The home was unable to provide the drug destruction and disposal system audit when requested by the Inspector. The Nurse Manager stated that the home did not complete the annual audit.

Failure to complete the drug destruction and disposal system audit annually, there was a missed opportunity to identified gaps and implement changes.

Sources: Interview with Nurse Manager.

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