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
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Public Report

Report Issue Date: December 17, 2024
Inspection Number: 2024-1514-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19, 20, 21, 22, 25, 26, 28, 29, 2024 and December 2, 3, 2024

The inspection occurred offsite on the following date(s): December 4, 5, 2024

The following Complaint intake was inspected:
- Intake #00122225, related to abuse and neglect.

The following Critical Incident (CI) intake(s) were inspected:
- Intake #00116421, Intake #00122274 and Intake #00124012, related to abuse and neglect;
- Intake: #00125206, related to improper care and falls prevention and management;
- Intake #00127390, related to a fall with injury;
- Intake #00127290, related to an injury of unknown cause and;
- Intake: #00130854, related to a disease outbreak.

The following intake(s) were completed in this inspection:

- Intake #00123202, Intake #00127323 and Intake #00128771, related to a disease outbreak;
- Intake #00122406, Intake #00123464, Intake #00125099, Intake #00125761, Intake #00127081, Intake #00128577, Intake #00130036 and Intake #00130233, related to falls prevention and management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
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 (7)
Plan of care
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 falls.

Rationale and Summary

A resident had an unwitnessed fall and had an intervention to manage falls. A Personal Support Worker found the resident with the intervention not in place.

A Registered Practical Nurse (RPN) confirmed that the intervention was not in place which may have contributed to the injury the resident sustained from the fall.

The resident sustained injury when the plan of care was not followed related to falls.

Sources: Review of a resident's clinical records and home's investigation notes; and interviews with a RPN and PSWs. [000704]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

The home's Falls Prevention and Management policy stated that when a fall occurred, all team members will ensure the resident was not moved before the completion of an initial assessment by a nurse.

A resident had an unwitnessed fall and two PSWs transferred the resident without being initially assessed by a nurse after their fall.

A RPN confirmed that the PSWs should not have transferred the resident until they were assessed by the nurse.

The resident was at a risk of injury when they were transferred by the PSWs before an initial assessment was completed by a nurse after their fall.

Sources: Review of the home's Falls Prevention and Management Policy, revised March 2023; and interviews with a RPN and a PSW. [000704]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the falls prevention and management program strategies to reduce or mitigate falls in monitoring a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the Fall Prevention and Management Program Policy was complied with. Specifically, staff did not complete a monitoring record.

Rationale and Summary

The home's fall prevention and management policy, indicated that after an unwitnessed fall, the monitoring record must be completed.

A resident had an unwitnessed fall and the monitoring record was not completed which was acknowledged by two registered nurses (RNs).

When the monitoring record was not completed, there was a risk of delayed treatment if the resident had a change in status.

Sources: Review of a resident's clinical records and Falls Prevention and Management Program Policy, dated March 2023; and interviews with RNs. [000704]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

Specifically, the home failed to ensure that Additional Precautions included additional personal protective equipment (PPE) requirements in the appropriate selection application, removal and disposal, as required by Additional Requirement

9.1(f) under the IPAC Standard.

Rationale and Summary

A resident home area (RHA) was in a COVID-19 outbreak. Signage for additional precautions was posted at the entrance of a resident's room.

A housekeeping aide (HA) did not remove and discard their surgical mask after cleaning and exiting the resident's room. The HA acknowledged they did not remove their mask after exiting the additional precautions room as required.

There was a risk of infection transmission to staff and residents when the HA failed to remove and discard their mask after cleaning a resident's room on additional precautions.

Sources: Observation in one RHA; review of IPAC Standard for Long Term Care Homes, revised September 2023; and interview with a HA and other staff. [000755]