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

Public Report

Report Issue Date: February 20, 2025

Inspection Number: 2025-1514-0001

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

INSPECTION SUMMARY

Inspection occurred onsite on the following date(s): January 28 – 31, 2025, and February 3, 4, 6, 7, 10 – 14, 18 – 20, 2025

The following Follow-up intake(s) were inspected:
· Intake: #00127097 – related to a Compliance Order (CO) previously issued to duty to protect
· Intake: #00127098 – related to a CO previously issued to the infection prevention and control (IPAC) program
· Intake: #00127099 – related to a CO previously issued to the responsive behaviour program
· Intake: #00127100 – related to a CO previously issued to the complaints procedure
· Intake: #00127101 – related to a CO previously issued to plan of care

The following Complaint intake(s) were inspected:
· Intake: #00138564, #00138017 - related to a bed refusal

The following Critical Incident (CI) intake(s) were inspected:
· Intakes: #00127419 [CI #3020-000083-24], #00129114 [CI #3020-000101-24], #00132496 [CI #3020-000122-24] – related to resident-to-resident abuse
· Intakes: #00128387 [CI #3020-000093-24], #00132490 [CI #3020-000123-24] – related to an injury of unknown cause
· Intake: #00128540 [CI #3020-000095-24] – related to improper care/neglect, wound care, repositioning, plan of care, physiotherapy, pain management, nutritional care and hydration program, recreation
· Intake: #00128686 [CI #3020-000097-24] – related to an incident of severe hypoglycemia resulting in hospital transfer
· Intake: #00129948 [CI #3020-000107-24] – related to improper care/neglect
· Intake: #00131104 [CI #3020-000117-24] – related to staff-to-resident physical abuse resulting in hospital transfer
· Intake: #00136828 [CI #3020-000006-25] – related to a disease outbreak
· Intake: #00132773 [CI #3020-000128-24] – related to a fall resulting in injury
· Intake: #00135663 [CI #3020-000143-24] – related to staff-to-resident physical and verbal abuse/neglect

The following intake(s) were completed:
#00132624 [CI #3020-000125-24], #00132655 [CI #3020-000126-24], #00135476 [CI #3020-000141-24], #00135928 [3020-000145-24], #00135924 [3020-000144-24], and #00135991 [3020-000004-25] - related to disease outbreaks; and

#00132881 [CI #3020-000129-24], #00133144 [CI #3020-000132-24], #00133711 [CI #3020-000135-24], #00133983 [CI #3020-000137-24], #00136071 [CI #3020-000001-25], and #00137112 [CI #3020-000007-25] - related to falls resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1514-0002 related to FLTCA, 2021, s. 24 (1)
Order #005 from Inspection #2024-1514-0002 related to O. Reg. 246/22, s. 102 (2) (b)
Order #004 from Inspection #2024-1514-0002 related to O. Reg. 246/22, s. 58 (4) (c)
Order #003 from Inspection #2024-1514-0002 related to FLTCA, 2021, s. 26 (1) (c)
Order #001 from Inspection #2024-1514-0002 related to FLTCA, 2021, s. 6 (7)

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
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee has failed to ensure that a resident was not neglected by staff when they requested care assistance on a specific date. Staff were scheduled at specific times to provide assistance with the resident's care. The home's investigation notes indicated that a Personal Support Worker (PSW) did not check on the resident at multiple scheduled times. The resident rang the call bell and waited for a period of time before providing the care need themselves, without any assistance.

Sources: CI report, investigation notes, resident's clinical records, interviews with the resident and Assistant Director of Resident Services (ADRS).

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 has failed to ensure that the staff and others collaborated with each other in the development of a resident's plan of care related to the processing of a prescribed medication. Following an acute medical incident, the physician authorized an order of a specific medication for the resident. The Registered

Practical Nurse (RPN) confirmed the order was not fully processed until a later date. There was no collaboration among staff to ensure the timely processing of the medication order.

Sources: Resident's clinical records, interviews with an RPN and other staff.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented. Specifically, documentation was not entered for the resident's specific treatments on multiple scheduled dates and times.

Sources: Resident's clinical records and interview with an RPN.

WRITTEN NOTIFICATION: Reporting certain matters to 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 an allegation of resident-to-resident physical abuse was immediately reported to the Director. The after-hours line was called and a CI report was submitted on the following day.

Sources: Resident's clinical records, CI report, home's investigation notes.

WRITTEN NOTIFICATION: Authorization for Admission to a Home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee has failed to ensure a written notice withholding approval for an applicant's admission to the long-term care home (LTCH) was based on a lack of nursing expertise to meet the applicant's care requirements. An email sent from the home's Admissions Coordinator to a Placement Coordinator indicated the Applicant was being refused a bed mainly due to behaviours and because they would not be a good mix for the unit.

Application documents indicated the applicant had multiple behaviours but was easily redirected. The ADRS indicated the home had internal and external Behavioural Supports Ontario (BSO) resources and staff were experienced in

working with residents with a range of responsive behaviours. They also indicated the applicant's care needs did not exceed the nursing expertise of the home, but rather the withholding of approval was due to not having enough staff to manage the number of residents on the unit with responsive behaviours.

Sources: Applicant's application documents, refusal letter, home's internal email, interview with ADRS.

WRITTEN NOTIFICATION: Authorization for Admission to a Home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (b)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;

The licensee has failed to ensure a detailed explanation of supporting facts, as they relate to both the home and the applicant's condition and requirements for care, were provided in a letter when approval for admission was withheld. The letter withholding admission indicated the complexity of care required by the applicant exceeded the scope of nursing care that could be provided. The ADRS acknowledged a detailed explanation of supporting facts was not provided.

Sources: Applicant's application documents, refusal letter, interview with ADRS.

WRITTEN NOTIFICATION: Authorization for Admission to a Home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 51 (9) (d)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(d) contact information for the Director.

The licensee has failed to ensure a written notice withholding approval for an applicant's admission to the LTCH included contact information for the Director. In reviewing the letter, the ADRS acknowledged contact information for the Director was not provided.

Sources: Refusal letter, interview with ADRS.

WRITTEN NOTIFICATION: Required Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program was developed and implemented in the home to identify and manage a resident's pain.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and protocols developed for the pain management program were complied with.

Specifically, staff did not comply with the pain identification and management policy that indicated for a new pain, the comprehensive pain assessment, in addition to the use of the Pain Assessment in Advanced Dementia (PAINAD) were to be completed. A resident was found with altered skin integrity and swelling to a specific area on their body. At a later date, the Nurse Practitioner (NP) assessed the resident and documented their findings. They ordered an immediate series of diagnostic tests to rule out acute injuries, and non-pharmacological pain interventions. A nurse completed the PAINAD that same day, however, a comprehensive pain assessment was not completed until a later date.

Sources: Resident's clinical records, policy Pain Identification and Management, interview with a Nurse Manager (NM).

WRITTEN NOTIFICATION: Responsive Behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when multiple residents were demonstrating responsive behaviours, actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions and that the residents' responses to interventions were documented.

1) A resident was demonstrating responsive behaviours. The Behavioral Supports

Ontario - Dementia Observation System (BSO-DOS) monitoring was not completed for the resident on multiple shifts.

Sources: Resident's BSO-DOS monitoring tool, policy Responsive Behaviour, interview with a BSO lead.

2) Two residents demonstrated responsive behaviours. A Responsive Behaviour Debrief Tool was not completed for both residents after an altercation between them. Further, BSO-DOS monitoring was not completed for one of the residents over a specific period of time.

Sources: Residents' clinical records, interview with a BSO lead.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that the dining service included proper technique including safe positioning when assisting a resident with eating. The resident's care plan indicated due to specific risks, they were to be positioned in a specific way while eating. The resident was observed in a specific position while being assisted with eating by a Student PSW. A PSW and RN entered the room at separate times during the assisted feeding and both adjusted the resident's positioning. The PSW confirmed that the resident was at risk of an adverse outcome if they were not

positioned appropriately.

Sources: Observation, resident's clinical records, interviews with a Student PSW, PSW and RN.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #011 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 failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented as it pertained to additional precautions.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), under section 9.1(f), at minimum, additional precautions shall include additional personal protective equipment (PPE) requirements including appropriate selection. A PSW did not don appropriate eye protection when entering a room where a resident was on droplet contact precautions (DCP).

Sources: Observations, interview with a PSW.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a Housekeeper (HSK) and a PSW participated in the implementation of the IPAC program.

1) A HSK did not don protective eyewear appropriately while cleaning a resident's room on DCP isolation. The resident had a specific infection and was noted to be symptomatic.

Sources: Observations.

2) A PSW did not doff PPE in the correct sequence, as they were observed removing their isolation gown prior to removing their gloves after exiting a resident's room on DCP isolation. The resident had a specific infection and was noted to be symptomatic.

Sources: Observations.

WRITTEN NOTIFICATION: Emergency Drug Supply

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 132 (b)
Emergency drug supply
s. 132. Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;

The licensee has failed to ensure that when maintaining an emergency drug supply of a specific medication for the home that a written policy was in place to address the location and access to the specific medication. The home's policy indicated every nursing station would have a treatment kit which may include the specific medication. A note affixed to the side of two treatment kits indicated the location of the specific medication. Inside one of the treatment kits, a note indicated two locations for the specific medication. The Director of Resident Services (DRS) indicated the location of the specific medication had changed twice in the past few years.

A resident experienced an acute medical incident where an RN responded and looked for the specific medication where it had previously been stored, but was unable to find it. A second RN was called for assistance and was also unable to find the specific medication. The first RN learned the next day from a NM of the new location of the specific medication.

Sources: Observations, resident's clinical records, policy Diabetes Management - Hypoglycemia, interviews with an RN and the DRS.

WRITTEN NOTIFICATION: Administration of Drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a specific medication was administered to a resident in accordance with the directions for use specified by the prescriber. The resident experienced an acute medical incident. Their medical directive indicated the specific medication was to be administered if this acute medical incident occurred. Two RNs were unable to find the specific medication, and consequently it was not administered as specified by the prescriber.

Sources: Resident's clinical records, interview with an RN.

COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 an authorized person described in subsection (2.1), if clinically indicated;

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

The licensee shall:

1) Provide in-person education to all registered staff on a specific unit, on the home's skin and wound policies and procedures.

a) Maintain a record of the education and training provided, including the content, date, signature of attendants, and the name of staff member(s) who provided the education.

2) Develop an audit tool to monitor and document completion of weekly skin assessments for residents who have altered skin integrity for four consecutive weeks.

a) Maintain a record of the audits completed, including date, shift time, person completing audit, observations made and content of on-the-spot education provided and/or other corrective actions taken where required.

3) Retain all records until the Ministry of Long-Term Care (MLTC) has deemed this order has been complied.

Grounds

The licensee has failed to ensure that multiple residents with altered skin integrity were reassessed at least weekly by a registered staff.

1) A resident had altered skin integrity on a specific body part and received a skin and wound assessment that day and on the following day. As per an interview with an RPN and the home's wound care management policy, the altered skin integrity should have been reassessed at least weekly by a nurse. The resident's clinical record indicated that no skin and wound reassessments were completed on multiple dates. Failure to ensure that the resident's altered skin integrity was reassessed at least weekly affected monitoring of their condition.

Sources: Resident's clinical records, policy Skin and Wound Program: Wound Care Management, interview with RPN.

2) A resident had altered skin integrity on a specific body part. It was assessed on a specific date and found to be deteriorating. Ressessments at least weekly were not completed on multiple dates. On a specific date, the resident was transferred to another facility where a complication of the altered skin integrity was determined. Failure to ensure that the resident's altered skin integrity was reassessed at least weekly potentially affected monitoring and responding to a deteriorating condition.

Sources: Resident's clinical records, interview with RN.

3) A resident was found to have altered skin integrity on a specific body part. It was first assessed by staff on a specific date. The altered skin integrity was not reassessed on multiple dates. Failure to ensure that the resident's wound was reassessed at least weekly may have affected monitoring of the wound and increased risk of deterioration.

Sources: Resident's clinical records, interview with an RN.

This order must be complied with by April 2, 2025

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.