Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 10, 2014 | 2014_219211_0006 | T-641-13 | Complaint |

**Licensee/Titulaire de permis**

VILLA COLOMBO HOMES FOR THE AGED, INC.
40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9

**Long-Term Care Home/Foyer de soins de longue durée**

VILLA COLOMBO HOMES FOR THE AGED INC.
40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

JOELLE TAILLEFER (211), SUSAN SEMEREDY (501)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): February 4, 5, 6, 2014.**

**During the course of the inspection, the inspector(s) spoke with interim CEO, director of resident services, physician, RAI-MDS coordinator and interim director of care, social worker, physiotherapist, registered staff, food service manager, registered dietitian, personal support workers, dietary aide, resident and resident's family.**

**During the course of the inspection, the inspector(s) observed the provision of care, observed one meal service, reviewed residents'records, reviewed menus, reviewed the food production sheets.**

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

**Dignity, Choice and Privacy**
**Falls Prevention**
**Food Quality**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care sets out clear directions for the staff and others who provide care to the resident.
Record review revealed that resident #1's care plan indicates that extra portions be provided when resident is hungry whereas the dietary kardex indicates that the resident is to be given double portions at every lunch and supper. Interviews confirmed that staff are confused as to whether dietary aides are to provide double portions on a regular basis or if personal support workers are to provide the extra portions only when resident is hungry. [s. 6. (1) (c)]

2. The licensee failed to ensure the care set out in the plan of care is provided to the resident.
Record review and interviews confirmed that resident #1's plan of care includes offering extra portions when the resident is hungry. Staff interviews revealed that resident #1 does not communicate but does show that he/she is hungry by scraping the plate clean. Observation of a lunch meal on February 5, 2014 revealed that resident #1 was not offered extra portions even though he/she ate all food provided and scraped his/her plate. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions for the staff and others who provide care to the resident and that care set out in the plan of care is provided to the resident, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to promote the resident POA's right to give or refuse consent to treatment which consent is required by law.
Clinical record review and staff interview confirmed that the family was not informed by the registered staff that the resident #1's medications regime was changed. The physician's order indicates that specific medications were increased, discontinued and started on an identified date. Staff interview confirmed that the box indicating that the resident/POA was notified did not contain a check mark and the progress notes did not demonstrate that the family was informed. [s. 3. (1) 11. ii.]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure planned menu items are available and offered to the resident at each meal and snack.
Record review revealed that resident #1 is on a therapeutic texture-modified diet. Observation of a lunch meal on February 5, 2014 revealed that resident #1 was provided an entree instead of a soup and was not offered bread as per planned menu. Interviews confirmed that resident #1 was not offered menu items as planned. [s. 71. (4)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (2) The food production system must, at a minimum, provide for, (g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that menu substitutions are documented on the production sheet.
It was observed that a menu change took place at the lunch meal on February 5, 2014. Chicken fingers were changed to turkey schnitzel and staff interview confirmed that a switch occurred between the previous day and the current day due to insufficient product. Observation in the kitchen revealed that the changes were not documented on the production sheet even though a separate sheet was used to record the switch and available in the food service office. [s. 72. (2) (g)]

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**Issued on this 10th day of February, 2014**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

SUSAN SEMEREDY, Joelle Taillefer