Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2019	2019_631210_0021	000987-19, 012154-19, 012785-19	Complaint

Licensee/Titulaire de permis

Friuli Long Term Care
7065 Islington Avenue Woodbridge ON L4L 1V9

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

Villa Leonardo Gambin
40 Friuli Court Woodbridge ON L4L 9T3

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

SLAVICA VUCKO (210)

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): September 24, 25, 26, 27, 30, October 1, 2, 3, 4, and 7, 2019.

The following Complaint intakes were inspected:
- Log #000987-19 and 012154-19, related to infection prevention and control and staffing,
- Log #012785-19, related to transfer and personal support services.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Personal Support Workers (PSW), Substitute Decision Makers (SDM) and family members of residents.

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed clinical records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

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 has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A complaint was submitted to the Ministry of Long Term Care (MLTC) on a specified date from a family member of resident #002 about improper transfer and personal care.

A review of resident #003's physiotherapist (PT) assessment record indicated the resident should be transferred with a particular mechanical lift from approximately one year ago. Interview with the PT confirmed that resident #003 should have been transferred according to their recommendation, and that registered staff should have updated the written plan of care.

A review of resident #003's written care plan under the transfer focus indicated the transfer status was updated on a specified date to a different mechanical lift. Before the update, they indicated two options for transfer with two types of mechanical lifts for a specified period of one year.

Interview with RN #111 indicated resident #003's written plan of care was not updated according to the PT assessment for a period of approximately one year and the resident had not been transferred appropriately for the same time period [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided

to the resident as specified in the plan.

A complaint was submitted to the Ministry of Long Term Care (MLTC) on a specified date from a family member of resident #002 about improper transfer and personal care.

Interview with the family member of resident #002 indicated that they suspected that on a specified date the resident was transferred improperly because the staff used a different mechanical lift than specified in the care plan. They further indicated that the improper transfer was happening for more than a year. According to the family member the resident complained to the family that two staff were rough while providing care.

A review of resident #002's clinical record indicated the resident had mild cognitive impairment and specific diagnoses. They were able to communicate with short answers, in their native language.

A review of the written plan of care for transfer and toileting indicated that resident #002's written plan of care for transfer was updated on a specified date to a different type of mechanical lift. The section for bathing did not specify which lift staff to use during bathing, only that, since a specified date, the resident required two staff total assistance for bathing.

A review of the PT assessment record indicated that on a specified date they recommended resident #002 to be transferred with a particular mechanical lift for all type of transfers. The PT assessed the resident quarterly for period of one year to be transferred using the same particular mechanical lift as mentioned above for all type of transfers such as from bed to wheelchair, during toileting and bathing.

Interview with PSW #109 indicated they transferred resident #002 using a different type of mechanical lift during bathing on a specified date and they were aware that the resident should be transferred with another type of mechanical lift when providing bathing. They further indicated that on a few occasions they were transferring the resident by themselves when using one of the mechanical lifts, without a second staff being present during the transfer.

Interview with RPN #106 indicated they updated resident #002's written plan of care on a specified date, the resident to be transferred with a particular mechanical lift and they did not review and consider the PT's assessments and recommendations for the transfer to be with the particular type of lift that the PT recommended.

Interview with the DOC indicated the home learned from resident #002's family member that the resident was inappropriately transferred and disciplined the staff involved.

Interview with ADOC #100, and DOC indicated that the expectation is registered staff to follow the recommendations from PT for transfer and update the written plan of care accordingly. They acknowledged that resident #002 was not transferred according to the transfer assessment by PT and by two staff when using mechanical lifts. [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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A complaint was submitted to the MLTC on a specific date, from a family member of resident #002 about how personal care was provided.

Interview with the family member of resident #002 indicated that the resident reported to them that PSW #110 was rough during providing care to them, specifically while a particular care activity for a period of several months. The family member stated that PSW #110 did not provide assistance with the above mentioned care activity in an appropriate and respectful manner. They considered this method of personal care as dangerous because the resident did not feel comfortable.

Interview with PSW #110 confirmed that during several occasions they provided assistance with the specific care activity to resident #002 that was not according to the everyday practices and not in a same manner as when provided in the resident's washroom. PSW #110 indicated that they used a particular personal care item if the specific care activity was provided in the resident's washroom, and they did not use the above mentioned personal care item for the same type of care activity in another care area of the home. The PSW indicated that when they were informed that the resident was not comfortable with the specific personal care being provided without using the above mentioned personal care item, they stopped this method.

Interview with the ADOC and Administrator indicated that the home's practice was staff to use a specified personal care item when providing the above mentioned personal care. They indicated that when they learned that PSW #110 provided the specific personal care to resident #002 in an inappropriate manner they informed the PSW not to do it.

Upon discussion with the ADOC and Administrator, they acknowledged that resident #002 was not provided specific personal care according to the home's practice. The method how the specific personal care was provided to resident #002 did not fully recognize the resident's individuality and disrespected the resident's dignity. [s. 3. (1) 1.]

Issued on this 31st day of October, 2019

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

Original report signed by the inspector.