Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 8, 2022	2022_631210_0003	000485-21, 001126-21, 003299-21, 007208-21, 008648-21, 009553-21, 014203-21, 015189-21, 017070-21, 017709-21	Critical Incident System

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), WING-YEE SUN (708239)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 8, 9, 10, 11, 14 and 15, 2022, on-site and February 16, 2022 off-site.

During the course of the inspection the following Critical Incident System (CIS) reports were inspected:
-intake #017709-21 associated with complaint intake # 017975-21,
-intake #000485-21 (CIS #2947-000001-21),
-Intake #001126-21 (CIS #2947-000002-21),
-intake #003299-21 (CIS #2947-000003-21),
-intake #007208-21 (CIS #2947-000008-21),
-intake #008648-21 (CIS #2947-000010-21),
-intake #009553-21 (CIS #2947-000012-21),
-intake #014203-21 (CIS #2947-000015-21),
intake #015189-21 (CIS #2947-000016-21) and
-intake #017070-21 (CIS #2947-000018-21) related to falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support workers (PSWs), Behavioral Support Ontario (BSO) Lead, Physiotherapist (PT), Infection Prevention and Control (IPAC) Lead, residents and family members.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed the home's internal investigation notes, and relevant policies and procedures.

A mandatory Infection Prevention and Control (IPAC) check list was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.

- **1 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. (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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in the plan.

A Critical Incident System (CIS) report submitted to the Ministry of Long Term Care (MLTC) indicated resident #012 fell on a specified date, and was transferred to the hospital. The fall resulted in injury and a change in health status.

Resident #012's care plan related to falls prevention indicated the resident was at risk for falls. Interventions were implemented to prevent falls.

Observations by inspector #708239 on two different dates indicated resident #012 was not using the specified falls prevention interventions/equipment.

PT #125 indicated that the specified falls prevention interventions or equipment would be recommended for residents who were at risk for falls and attempting to transfer themselves. Two staff reported resident #012 did not use the falls prevention interventions/equipment for falls prevention.

Resident #012's was not provided with the required falls prevention interventions as specified in their care plan.

Sources: Observations; resident #012's care plan and clinical records; and interviews with staff. [s. 6. (7)]

2. The licensee has failed to ensure that residents #011, #012 and #013 were reassessed and the plan of care was reviewed and revised when the resident's care set out in the plan was no longer necessary.

A CIS report submitted to the MLTC indicated resident #011 fell on a specified date and was transferred to the hospital because of an injury. The resident's health status related to locomotion changed.

Resident #011's care plan related to locomotion, indicated the resident ambulated with a walker on the unit. Progress notes indicated the resident used a wheelchair after their return from hospital.

Observations by inspector #708239 on two different occasions, indicated resident #011 was ambulating on the unit in their wheelchair.

Two staff indicated that the resident used a wheelchair to ambulate and not a walker after the resident returned from hospital.

Resident #011's plan of care was not revised when the resident's ambulation status changed.

Sources: Observations; resident #011's care plan and progress notes; and interviews with staff. [s. 6. (10) (b)]

3. A CIS report submitted to the MLTC indicated resident #013 fell on a specified date, in another resident's room and was transferred to the hospital. The fall resulted in an injury and required treatment.

Resident #013's plan of care related to falls prevention interventions, indicated the use of a a particular fall prevention device to alert staff when they tried to get up from their bed. Resident #013 was identified as high risk for falls with gait and balance problems and able to walk and transfer independently.

Observation by inspector #708239 on two occasions, indicated resident #013 was walking independently on the unit and their bed was not equipped with the required falls

prevention device.

At least two staff indicated resident #013 did not need the above mentioned fall prevention device.

Resident #013's plan of care was not revised and updated when the above mentioned fall prevention device was no longer necessary.

Sources: Observations; resident #013's care plan and clinical records; and interviews with staff. [s. 6. (10) (b)]

4. A CIS report submitted to the MLTC indicated resident #012 fell on a specified date, and was transferred to the hospital. The fall resulted in an injury and a change in ambulation status.

Resident #012's care plan, indicated that the biggest falls risk was self-transferring and required a team member to assist with transfers. In contrast, resident #012's care plan related to toileting and transfers indicated that the resident was able to toilet and transfer independently. Observation by inspector #708239 showed a signage over resident #012's bed for a specified type of transfer .

At least two staff acknowledged that the resident was unable to toilet and transfer independently and required assistance of one person for transfers. The resident attempted to self-transfer.

Resident #013's care plan was not reviewed and revised when their level of care needs changed.

Sources: Observations; resident #012's care plan and clinical records; and interviews with staff. [s. 6. (10) (b)]

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 he care set out in the plan of care was provided to resident #012 as specified in the plan, and that residents were reassessed and the plan of care was reviewed and revised when the resident's care set out in the plan was no longer necessary, to be implemented voluntarily.

Issued on this 10th day of March, 2022

[redacted]

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

Original report signed by the inspector.