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
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Original Public Report

Report Issue Date: MAY 9, 2023
Inspection Number: 2023-1431-0004
Inspection Type: Complaint Critical Incident System
Licensee: Friuli Long Term Care
Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge

Lead Inspector	**Inspector Digital Signature**
Adelfa Robles (723)	Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2023.05.09 16:03:21 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 27-28, 2023 and May 1-3, 2023

The following intake(s) were inspected:
- Intake: #00021654 – [Critical Incident (CI): 2947-000004-23] – related to fall with injury.
- Intake: #00084817 – complaint related to Infection Prevention and Control (IPAC).

The following intake(s) were completed:
- Intake: #00021234 – [CI: 2947-000003-23] – related to fall with injury.
- Intake: #00086014 – [CI: 2947-000009-23] – related to fall with injury.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 9

The licensee has failed to ensure that the IPAC lead reviewed daily screening results of a resident, collected by staff to determine whether any action was required.

In accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard), specifically, additional requirement 2.2 required that the licensee ensure that the IPAC Lead reviews infectious disease surveillance results regularly to ensure that all staff were conducting infectious disease surveillance appropriately and ensure that appropriate action was taken to respond to surveillance findings.

Rationale and Summary
A resident was observed with respiratory symptoms for several days. The resident tested negative for a rapid screen with no confirmatory test for COVID-19 completed. Staff assigned to the resident stated there was no COVID-19 confirmatory test completed for the resident.

The home's Public Health (PH) liaison officer stated that any resident observed with symptoms of respiratory infection were expected to be on Droplet and Contact Precautions (DCP), complete a rapid test followed by a confirmatory COVID-19 test. Other infectious disease testing would be completed as required.

Assistant Director of Care (ADOC) stated that if a resident was observed with any respiratory symptom, staff were expected to isolate the resident, perform a rapid followed by a confirmatory COVID-19 test. Staff were also required to document their assessments and inform the IPAC Lead and/or the ADOC in the unit.

The IPAC Lead stated that residents with symptoms were monitored by staff. Residents who exhibited any symptoms of infection were to be included in the home's surveillance tracking documentation. The resident was not included in the home's infectious disease surveillance documents except in the Point Click Care (PCC) progress notes.

IPAC lead stated they did not review the progress notes or receive any reports from the staff regarding the resident's symptoms. IPAC Lead further stated that because the confirmatory test was not done for the resident, other infectious disease testing was not completed.

When the IPAC lead failed to review the daily infectious disease surveillance for a resident, the home was not able to implement appropriate action required to respond to surveillance findings.

Sources: IPAC Standard for Long Term Care Homes, April 2022, home's policy on Novel Coronavirus-COVID-19 Prevention & Management, IX-N-10.40 last revised 04/2023, home's Resident Unit Planner December 2022 to January 2023, a resident's clinical records, interviews with PH Liaison Officer and staff in the home.

[723]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they were assessed at least weekly by a member of the registered staff.

Rationale and Summary
The home's policy indicated that for resident exhibiting altered skin integrity including skin tears or wounds, registered staff was directed to complete an electronic weekly skin and wound assessment until healed.

A resident exhibited an altered skin integrity after a fall incident. There were no weekly skin and wound assessments completed.

Staff confirmed that weekly skin and wound assessments were missed for the resident twice. ADOC and the Director of Care (DOC) both stated that staff were expected to complete a weekly skin and wound assessment for residents with altered skin integrity.

There was a risk for delayed treatment and healing for a resident when their wound did not receive weekly assessment.

SOURCES: Home's policy on Skin & Wound Care Management Protocol, VII-G-10.90 last revised 04/2023, a resident's clinical records, CI #2947-000004 submitted, 2/27/2023 and staff interviews.

[723]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that when a resident was observed with a symptom of infection, immediate action was taken to isolate the resident and place them in a cohort as required.

Rationale and Summary
The home's policy indicated that for any residents whose daily screening showed symptoms of infection, they should be immediately isolated and placed on DCP.

A resident was observed with respiratory symptom on specified dates and was not placed on isolation.

Staff assigned to the resident confirmed that the resident had respiratory symptoms and received treatment. They did not recall if the resident was placed on isolation.

ADOC and the IPAC Lead both stated that for any resident exhibiting symptoms of infection, staff were expected to isolate the resident, complete a rapid and confirmatory COVID-19 tests as per PH requirements.

There was a risk of disease transmission when a resident was not isolated when they were observed with symptoms of respiratory infection.

Sources: IPAC Standard for Long Term Care Homes, April 2022, home's policy on Novel Coronavirus-COVID-19 Prevention & Management, IX-N-10.40 last revised 04/2023, home's Resident Unit Planner December 2022 to January 2023, a resident's clinical records, interviews with PH Liaison Officer and staff in the home.

[723]