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

Original Public Report

Report Issue Date: August 3, 2023	
Inspection Number: 2023-1431-0005	
Inspection Type: Complaint Critical Incident System	
Licensee: Friuli Long Term Care	
Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge	
Lead Inspector Fiona Wong (740849)	**Inspector Digital Signature** Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2023.08.10 13:18:02 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17-21, 24, 2023.

The following intake(s) were inspected:

- Intake: #00089382 - [Critical Incident (CI): 2947-000015-23] - related to falls prevention and management.
- Intake: #00090948, #00091137 and #00092689 - [CI: 2947-000017-23 and 2947-000018-23] - related to alleged neglect and improper care.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident and on the needs and preferences of that resident.

Rationale and Summary
The resident's specified care needs were not documented in their plan of care for three months following admission.

In speaking with multiple nursing staff, there were inconsistencies in the care provided to the resident.

Three months after admission, the resident's care plan was updated however multiple nursing staff stated that it was not reflecting their care needs.

Failure to develop and update the resident's care plan based on their needs increased the risk of providing inconsistent care, leaving their needs unmet.

Sources: interviews with two Personal Support Workers (PSWs), a Registered Practical Nurse (RPN), and an Assistant Director of Care (ADOC), the resident's care plan.

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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) (a)

The licensee has failed to ensure that the staff and others involved in the care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
On a specified day, PSW #105 observed the resident had developed a specified symptom but did not report it to the nurse.

On the next day, PSW #107 observed the resident had a worsening specified symptom and reported to an RPN, however the RPN denied receiving report about the worsening specified symptom that day.

Later on that next day, PSW #109 observed the resident had the same worsening specified symptom. It was not immediately reported to a Registered Nurse (RN) as they were on another unit. It was eventually reported to the RN towards the end of their shift when they returned to the unit.

An ADOC stated that the PSWs should have reported to the nurse immediately after observing the specified symptom.

Failure to collaborate in the assessment of the resident's change in health condition delayed their treatment.

Sources: Interviews with multiple staff and an ADOC, the home's investigation notes, the resident's progress notes.

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WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee has failed to ensure that staff use a specified falls prevention equipment in the home in accordance with manufacturers' instructions.

Rationale and Summary
A resident was identified to be at risk for falls. A specified falls prevention equipment was provided.

A PSW heard the resident calling out for help. When the PSW walked closer to the resident's room, the specified falls prevention equipment was not functioning at its usual setting. The PSW found the resident on their washroom floor.

Multiple nursing staff and the Director of Environmental Services (DES) all stated that when triggered, the specified falls prevention equipment is to function at their usual setting. The specified falls prevention equipment also activates a specified system when triggered.

The PSW indicated that on the day of the above incident, the specified system was not activated when the specified falls prevention equipment was triggered.

The DES confirmed that no work orders were received related to malfunction to the specified system and specified falls prevention equipment during that time.

The user manual for the specified falls prevention equipment states that the equipment has a factory default setting. The DES confirmed that the specified falls prevention equipment must be set to the factory default setting.

Failure to use the specified falls prevention equipment in accordance with the manufacturer's instructions may have delayed the staff's response to the resident.

Sources: Interviews with multiple nursing staff and the DES, the specified falls prevention equipment user manual.

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WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to comply with the process to assess a resident's altered skin integrity.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of a registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and must be complied with.

Specifically, staff did not comply with the licensee's skin and wound care policy when intact skin alteration was identified.

Rationale and Summary
On a specified day, RPN #110 identified an intact skin alteration on the resident.

The home's skin and wound care policy states that when a resident is experiencing intact skin alterations, nurses will complete a specified assessment weekly until healed.

RPN #106 and an ADOC confirmed that the specified assessment was not completed when the intact skin alteration was identified, and it should have been completed.

Failure to complete the required assessment put the resident at risk as there could have been a delay in identifying and managing the resident's skin condition.

Sources: interviews with RPN #106 and an ADOC, the resident's progress notes and clinical records, the home's skin and wound care policy.

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WRITTEN NOTIFICATION: Pain Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The licensee has failed to comply with their pain management program when new pain was identified for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the pain management program provide communication and assessment methods for residents who are cognitively impaired.

Specifically, staff did not comply with the licensee's pain management policy when the resident's pain was not thoroughly assessed using a pain assessment tool.

Rationale and Summary
The resident was assessed to have cognitive impairment.

On a specified day, the resident complained of pain. RPN #110 was aware and conducted a skin

assessment, but a pain assessment was not completed. No intervention was initiated for pain management.

The home's pain management policy directs nurses to screen for presence of pain and complete a pain assessment electronically when resident reports or exhibits signs and symptoms of pain following implementation of pharmacological and/or non-pharmacological interventions.

RPN #106 and an ADOC confirmed that an electronic pain assessment was not completed, and pain management intervention was not initiated when new pain was identified for the resident, and it should have been done.

Failure to follow the home's pain management policy delayed the resident's pain management treatment and not identifying the severity of the resident's pain.

Sources: interviews with RPN #106 and an ADOC, the resident's clinical records, the home's pain management policy.

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