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: October 30, 2023	
Inspection Number: 2023-1431-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Friuli Long Term Care	
Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge	
Lead Inspector Nrupal Patel (000755)	**Inspector Digital Signature** Nrupal Patel Nrupal Patel 2023.11.02 13:04:44 -04'00'
Additional Inspector(s) Carole Ma (741725)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12-13, 17-19, 2023.
The inspection occurred offsite on the following date(s): October 16, 2023.

The following Critical Incident (CI) intake(s) were inspected:
- Intake: #00096313 - [2947-000021-23] - related to resident to resident abuse.
- Intake: #00096791 - [2947-000024-23] - related to an injury of unknown cause.

The following Complaint intake(s) were inspected:
- Intake: #00097597 - related to concerns pertaining to the care of residents.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Pain 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 (9) 1.

The licensee failed to ensure that the provision of care as set out in the plan of care was consistently documented in two resident's clinical records.

Rationale and Summary

1) The Director received a complaint on a specified date, alleging the home was withholding pain medications.

The resident experienced pain. Their medication administration record (MAR) indicated a medication was scheduled to be given at specific time intervals daily. Their treatment administration record (TAR) indicated an intervention was scheduled to be applied at specific time intervals daily.

The resident's MAR revealed that a dosage of a medication was not signed off on a specific date. Their TAR revealed that the scheduled intervention was not signed off multiple times in a one month period.

Registered Practical Nurses (RPNs) #101 and #103 could not confirm whether they signed off on the medication and treatment administration nor could they confirm whether they were administered to the resident.

Associate Directors of Care (ADOCs) #108 and #109 confirmed that the scheduled medication and treatment were not signed off as described.

Failure to document resident's medication and treatment administration placed the resident at risk of compromised pain management.

Sources: resident's clinical records; interviews with RPNs #101, #103, ADOCs #108 and #109.

[741725]

2) A Resident's MAR indicated a medication was ordered to be given at specific time intervals daily. The administration of the medication in a one month period was not signed off multiple times.

ADOCs #108 and #109 confirmed that the scheduled medication for the resident was not signed off as required.

Failure to document the resident's medication administration placed them at risk of compromised management of their medical condition.

Sources: resident's clinical records; interview with ADOCs #108 and #109.

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WRITTEN NOTIFICATION: Duty To Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulations 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary

On a specified date and time, a resident was heard speaking loudly and continuously. RPN #110 proceeded to check on the resident. RPN #110 found the resident was striking another resident. The struck resident sustained physical injuries as a result of the abuse. RPN #110 promptly intervened and separated the residents.

RPN #110 confirmed they witnessed a resident striking another resident. ADOC #108 and RPN #110 acknowledged an incident of physical abuse occurred.

Failure to protect a resident from physical abuse by another resident led to harm to their health and wellbeing.

Sources: CI #2947-000021-23; resident's clinical records; interviews with RPN #110 and ADOC #108.

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WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure resident was assessed using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial intervention.

Rationale and Summary

On a specified date, a resident experienced pain. On a specified date the resident was transferred to the hospital after a diagnostic test confirmed the resident had sustained an injury.

The home's pain and symptom management policy directed nurses to screen for presence of pain and complete a pain assessment tool when resident reports or exhibits signs and symptoms of pain followed by implementation of pharmacological and/or non-pharmacological interventions.

RPN #111 stated that on a specified date, the resident was given medication and an additional non-pharmacological intervention for comfort. Upon reviewing resident's clinical records, it was observed that no pain assessment tool was completed during the specified period, even though the resident continued to experience pain. RPN #112 confirmed that a pain assessment was not conducted for the resident on a specific date.

ADOCs #108 and #113 both confirmed no pain assessment tools were completed for the resident between the specified periods. They acknowledged that a pain assessment tool should have been completed for the resident when the resident was in pain and the interventions for pain management were not effective.

Failure to complete a pain assessment tool as per the home's policy, placed the resident at a risk of receiving ineffective pain management.

Sources: resident's clinical records; Interview with RPNs #111 and #112, ADOCs #113 and #108; the home's pain management policy (VII-G-30.30, last revised April 2019).

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure resident's injury that resulted in a significant change in their condition was reported to the Director within one business day.

Rationale and Summary

On a specified date, the resident reported pain. The resident was assessed by the physician, who ordered a diagnostic test. The resident was transferred to the hospital after a diagnostic test revealed an injury and returned to the home with a specific device.

A CI report for resident's injury was submitted to the Director multiple business days following the incident. ADOCs #108 and #109 acknowledged that the incident should have been reported to the Director within one business day.

Failure to report the incident to the Director within one business day did not place the resident at risk.

Sources: CI #2947-000024-23; resident's progress notes; Interview with ADOCs #108 and #109.

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