

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 16, 2024

Inspection Number: 2024-1431-0003

Inspection Type:

Complaint
Critical Incident (CI)

Licensee: Friuli Long Term Care

Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7 - 9 and 12 - 14, 2024.

The following intake(s) were inspected:

- Intake: #00117687 / CI #2947-000016-24 was related to outbreak of communicable disease.
- Intake: #00118233 / CI #2947-000020-24 was related to neglect of care.
- Intake: #00121572 / CI #2947-000028-24 was related to fall.
- Intake: #00117975 was a complaint related to aspects of care.

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

The following intake(s) were completed with this inspection:

- Intake: #00112403 / CI #2947-000011-24, Intake: #00119222 / CI #2947-000022-24, Intake: #00119374 / CI #2947-000023-24 and Intake: #00119637 / CI #2947-000024-24 were related to fall.
- Intake: #00116152 / CI #2947-000014-24 was related to outbreak of communicable disease.
- Intake: #00118004 / CI #2947-000017-24 - LTCH C/R 2024 - was related to improper care.

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

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that Additional Requirement was followed in the Infection Prevention and Control (IPAC) program in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Section 7.3 The licensee shall ensure that the IPAC Lead plans, implements, and tracks the completion of all IPAC training and b) Ensures that audits are performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

Specifically, the licensee did not ensure that all staff can perform the IPAC skills required as part of their role.

Rationale and Summary:

Review of the IPAC Personal Protective Equipment (PPE) and Hand Hygiene (HH) audits completed by the home for a period of three months revealed there were no IPAC audits involving the kitchen and environmental services staff.

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

IPAC Lead stated they did not perform IPAC skills audits such as PPE or HH on dietary or housekeeping staff. Environmental Services Manager (ESM) stated there were no IPAC skills audits completed for maintenance and laundry staff.

Failure of the home to conduct regular quarterly audits to ensure all staff can perform IPAC practices specific to their role increased the risk of infection transmission and spread.

Sources: IPAC Audits, IPAC Audits Quarterly Summary, interviews with IPAC Lead and ESM.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a written complaint made to the licensee concerning the care of a resident was provided with a response that complies with paragraph 3, within 10 business days of the receipt of the complaint.

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

Rationale and Summary

Family member of a resident sent an e-mail to the Director of Care (DOC), complaining about neglect of care. The complainant was not provided with a response within 10 business days of the receipt of the complaint.

A complaint management policy titled 'Complaints Management Program (ON)', which required a member from the leadership team to prepare a written response letter within 10 days, and review with Executive Director prior to sending to the complainant, was not followed.

The DOC acknowledged that there was no written response letter given to the complainant for a complaint.

Failure to provide a written response to the complaint did not affect the safety and well being of the resident.

Sources: Review of CI report, investigation notes including communication with the complainant, policy titled 'Complaints Management Program (ON)'; interview with DOC.