Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 18, 2015	2015_417178_0015	010860-15	Complaint

Licensee/Titulaire de permis

VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC.
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

Long-Term Care Home/Foyer de soins de longue durée

VILLA COLOMBO SENIORS CENTRE
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 22, 29, October 1, 14, 20, 21, November 9, 10, December 15, 16, 17, 2015.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Chief Executive Officer of the home's management company, registered nursing staff, personal support workers (PSWs), physician, psychiatric resource consultant, family members of a resident, a resident.
During the course of the inspection, the inspector also reviewed resident and home records, and reviewed email correspondence and video footage of resident #01, as supplied by the complainant and the licensee.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain
Responsive Behaviours

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to receive visitors of his or her own choice is fully respected and promoted.

Interviews with the home's acting Administrator confirmed that the licensee has restricted resident #01 from receiving any visits from his/her family member (FM) #110 and that family member's spouse, since an identified date approximately two months ago.

Written correspondence from FM #110 to the Ministry of Health and Long-term Care confirmed this fact, as did a review of Resident # 01's progress notes.

Review of resident #01's progress notes and interviews with front line staff indicated that FM #110 has visited the resident one or more times daily since the resident entered the home, until the visits were restricted on an identified date approximately two months ago. Interviews with the home's acting Administrator, personal support workers and registered staff, all indicated that the resident displayed no objection to being visited by FM #110, and that FM #110 would often bring snacks and food which the resident enjoyed. Interview with staff #103 indicated that prior to an identified date when resident #01's condition declined, the resident would appear to enjoy the visits from FM #110 and his/her spouse, and would sometimes sing with them, making it appear that the resident was happy. According to staff #103, FM #110 would sometimes assist with aspects of the resident's care, which the resident was more likely to accept from FM #110 than from the staff. Staff #101 also stated that FM #110 would assist with the resident's care at times, but that FM #110 also interfered with the staff when they attempted to encourage the resident to accept certain care.

During an interview on December 14, 2015, the resident indicated in his/her answers to the inspector's questions that he/she enjoys visits from FM #110 and FM #110's spouse, and would like for them to visit her.

Review of resident #01's records indicated that the persons who share POA for resident #01 authorized the home and its employees to prohibit FM #110, and his/her spouse from entering the premises and having any contact with the resident at the resident's residence at Villa Colombo, Vaughan.

Review of a copy of the resident's POA document, dated approximately 17 years before the resident entered the home, indicated that in the event of any legal incapacity on the part of resident #01, the POAs (FM #112, #113, and #114) are authorized to make decisions regarding his/her property, personal care, and to give or refuse consent to

treatment to which the Consent to the Treatment Act, 1992 applies. The POA document does not authorize the three appointed attorneys to make decisions about the resident's shelter or safety, or state that the POAs are authorized to choose or restrict visitors to the resident.

Review of the resident's medical diagnoses and consultation notes from his/her physician and geriatrician indicated that resident #01 suffers from an identified chronic medical condition. A Capacity Assessment conducted approximately two months ago, states that the resident is not capable of making decisions about personal care, health care, and property.

During interviews with the acting Administrator on October 20, and November 9, 2015, the acting Administrator told the inspector that the home put this restriction into place at the request of the persons who share Power of Attorney (POA) for Resident # 01. The acting Administrator stated that the POAs told her that they were particularly upset over recent videotapes that family member #110 made of the resident without the resident's or POAs' permission, and sent to the Ministry of Health and Long-term Care. The acting Administrator also cited the home's concerns over the behaviour of FM #110 and his/her spouse within the home, including a recent verbal altercation between the spouse and FM #112 in a resident care area, and “intrusive demands/requests” from FM #110 regarding the resident's medications although FM #110 is not the legal POA, as reasons for implementing the POAs' request to prevent FM #110 from visiting the resident. Finally, the acting Administrator stated that concerns cited by the resident's Geriatrician in a recent consultation report on an identified date, in which the physician stated that FM #110's behaviour may be contributing to a change in the resident's behaviour, as further reason for imposing the visiting restrictions on FM #110.

An interview on October 21, 2015, with the Geriatrician who wrote the consultation report cited above, and who has treated the resident and conferred with the resident's POAs, confirmed his/her concern that unrestricted visitation by FM #110 may be causing harm to resident #01 by contributing to the resident's identified psychological condition, and also by interfering with the staff attempting to provide care.

Interview on December 15, 2015, with the home's acting Administrator and the Chief Executive Officer (CEO) of the home's management company, confirmed that the reasons for fully restricting FM #110's visits to resident #01 were a combination of the directive from the resident's three POAs to do so, and safety concerns the licensee has regarding the behaviours of FM #110 and his/her spouse. During the interview, the

following behaviours were cited as reasons for fully restricting FM #110 and his/her spouse from visiting resident #01:
-FM #110 has videotaped the resident without consent from the resident or the POAs.
-FM #110, who does not have POA for resident #01, has interfered with the resident's care by attempting direct the resident's care, and to obtain personal health information (PHI) from the staff regarding the resident.
-FM #110 has caused increased agitation to the resident. This is contradicted by the evidence gathered by the inspector in interviews of the direct care staff. These interviews did not reveal that visits from FM #110 or her spouse caused any increased agitation to the resident. The CEO also maintains that a video sent to him by FM #110 shows evidence of FM #110 taunting the resident, which could be considered a form of psychological abuse. The videos sent by the complainant have been viewed by the inspector, and no evidence of psychological abuse was observed.
-FM #110's spouse recently caused disruption to resident #01 and other residents, by engaging in a verbal altercation with FM #112.

The decision to fully restrict FM #110 and his/her spouse from visiting resident #01 was based on a directive from the resident's POAs, in addition to the safety concerns noted above. The POA agreement does not authorize the three appointed attorneys to make decisions about the resident's shelter or safety, which would need to be permitted by the POA agreement in order to authorize the attorneys to make decisions restricting the resident's visitors.

The safety concerns expressed by the licensee are not sufficient justification to fully restrict FM #110 and his/her spouse from visiting the resident, given the fact that FM #110 had been visiting the resident daily prior to the restrictions, and the resident has indicated he/she enjoyed the visits from FM #110 and FM #110's spouse, and wishes to be visited by them. The licensee did not make an attempt to manage these safety concerns while still fully promoting the resident's right to experience visits from FM #110 and her spouse. As a result, the resident's right to receive visitors of his/her choice has not been fully respected and promoted by the licensee. [s. 3. (1) 14.]

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 the resident's right to receive visitors of his or her own choice is fully respected and promoted, to be implemented voluntarily.

Issued on this 8th day of January, 2016

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

Original report signed by the inspector.