Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2018	2018_524500_0009	010460-18, 012516-18	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 (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

NITAL SHETH (500), JOY IERACI (665)

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): June 15, 18, 25, 26, 27, 28, 29, July 3, 4, 5, 6, 9, 11, off-site- July 16, and 19, 2018.

A Written Notification (WN) and Voluntary Plan of Correction (VPC) related to LTCHA, 2007, Regulation r. 50. (2) (b) (iv) were identified in Resident Quality (RQI) inspection #2018_751649_0012, Log # 013741-18, dated June 19, 2018, which was conducted concurrently with this inspection, and issued in this report.

A Written Notification (WN) and compliance order (CO) related to LTCHA, 2007, Act s. 3. (1) 11. iv. was identified during this inspection were issued under the concurrent complaint inspection #2018_751649_0013, Log # 003835-18 dated June 19, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care- Administrative (DOC-A), Physiotherapist (PT), Clinical Manager (CM), Maintenance, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Residents, and Family Members.

During the course of the inspection the Inspector observed staff to resident interactions, reviewed relevant policies, reviewed staff training records, residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Ministry of Health and Long-term Care (MOHLTC) received a complaint indicating resident #034 had impaired skin integrity, and a concern related to the resident's continence care.

-A review of the resident's written plan of care indicated that the resident was using a bedrail assistive mobility bar for bed mobility and transferring in and out of the bed.

A review of progress note indicated that the resident sustained an injury during a transfer from the wheelchair to the bed while assisted by Personal Support Worker (PSW) #137 due to possible cause of the resident scratching the foot rest of the wheelchair.

Observation conducted on an identified day, in the presence of Inspector #665 indicated that the resident's bed rail had an open metal part, and a sharp edge in the middle corner of the joint of the rail.

Interview with PSW #137 indicated that the PSW assisted the resident to transfer from the wheelchair to the bed on an identified day, and the resident's foot was caught in the bottom part of the bed rail, and the open area of the metal part rubbed the resident's leg and caused an injury to the resident. PSW #137 indicated that they also sustained an injury on their leg because of this metal part of the bed rail during this transfer. The Physiotherapist (PT) was informed and the above mentioned areas were covered with a soft material on the same day.

Interview with Registered Practical Nurse (RPN) #126 indicated that PSW #137 reported the resident sustained an injury and the treatment was provided.

During an interview, the PT indicated that the above mentioned parts of the resident's bed rail were covered with a pool noodle, to prevent any injury to the resident after it was reported by PSW #137.

The Inspector conducted an observation with the Director of Care- Administrative (DOC-A) on an identified day, and PSW #137 demonstrated, how the resident sustained an injury during a transfer from the wheelchair to the bed.

In an interview, the maintenance confirmed that the resident's bed rail was replaced when the order was received from the clinical manager in the home.

Interviews with PSW #137, RPN #126, #124, Registered Nurse (RN) #132, PT,

Maintenance, and the DOC- A confirmed that all devices used for the residents should not have any sharp edges or areas so as to be safe for residents all the time.

-Interview with the resident #034's Substitute Decision Maker (SDM) indicated that on an identified day, the resident showed the SDM, an injury to an identified body area, it was painful to touch. The SDM reported it to the home and the home informed the SDM that the resident was sitting with three other residents sitting in big wheelchairs at the dining table and while pushing the resident under the table, the resident might have sustained an injury.

During an interview, with an interpreter conducted by Inspectors #649, and #665, the resident was not able to provide any information about the cause of their injury.

A review of the pictures provided by the SDM indicated that the resident had an impaired skin integrity on the shin area.

A review of progress notes indicated that RPN #115 reported to the SDM that the resident's injury and impaired skin integrity could be happening in the dining room as there were four wheelchairs at the table where the resident was sitting. RPN #105 indicated to the SDM that going forward, footrests of all those wheelchairs will be placed to the lowest position and a specified device will be applied to the resident's lower legs for extra protection.

In an interview, PSW #137, and #126 indicated that there were big wheelchairs at the resident's dining table, and the resident might have sustained an injury because of banging their legs into the dining table or to other resident's foot rest. PSW #137 indicated that the staff should have been more careful while positioning these residents to the dining table.

In an interview, RPN #115 indicated that in the dining room, the resident's feet are extended, and other residents' foot rests were down. RPN #115 indicated that the resident was identified with injury and further indicated that the injury likely happened by banging the resident's wheelchair in the dining room. [s. 5.]

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 home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

MOHLTC received a complaint indicating resident #034 had impaired skin integrity, and a concern related to the resident's continence care.

A review of the Critical Incident System (CIS) report indicated that resident #034's family called the police regarding an alleged incident. The resident had moderate cognitive impairment. The resident had told the family members that a PSW had twisted the resident's arm while changing their incontinent product after the resident was resisting the PSW, which resulted in an impaired skin integrity.

Interview with the resident #034's Substitute Decision Maker (SDM) indicated that on an identified day, the resident showed the SDM, an injury to the shin area, it was painful to touch. The SDM reported it to the home and the home informed the SDM that the resident was sitting with three other residents sitting in big wheelchairs at the dining table and while pushing the resident under the table, the resident might have sustained an injury. The home called the SDM on two different occasions and informed the resident had two new impaired skin integrity, and the SDM called the police. The area was

swollen and painful to the resident. The home did not provide a cause of the resident's impaired skin integrity. The resident reported to the SDM and one of the SDM's family members about staff twisting the resident's wrist at night during care.

During an interview, with an interpreter conducted by Inspectors #649, and #665, the resident confirmed that the staff member grabbed their hand and twisted the hand and caused pain. The resident also indicated that they are not able to sleep well in the night time and was unable to provide a reason for not able to sleep well at night. The resident indicated that sometimes staff were gentle during care, sometimes not.

A review of the resident's pictures indicated that the impaired skin integrity got worse in five days.

A review of the progress notes indicated that the resident was identified with new impaired skin integrity with mild swelling on some areas on different occasions. The note made by Medical Director (MD) indicated the impaired skin integrity and ordered for an x-ray. Another note made by the DOC-A indicated that the impaired skin integrity was appeared to be spreading down in the direction of gravity. A strike out note indicated that SDM called the home and informed that the resident reported to the SDM that staff member twisted the resident's arm. A note dated on an identified day, indicated that the doctor assessed the resident and documented that the resident was known to bang arms on the side rails. A note made by the administrator, indicated that the SDM called the police. The SDM indicated that the resident reported that on an identified day, the staff member came to the resident to provide care, the resident refused the care, staff member insisted on care and allegedly twisted the resident's arm while providing care when the resident refused the care. A review of the progress note made by MD indicated the resident had an injury.

A review of the progress notes indicated that there was no note documented in the point click care (PCC) by staff about the resident's care for six days including the day of the incident.

Interview with PSW #133 denied twisting the resident's wrist, and indicated that the resident was not resistive during the care on an identified day during the shift. PSW #133 indicated that the resident was resistive every night, and dropped all bedding from the bed contrary to their statement earlier that on the incident day, during the shift, the resident was very cooperative and not agitated during care.

A review of PSW #133's written statement identified in the home's investigation indicated that the PSW #133 confirmed that the resident was cooperative during care even though the resident was restless. This is contrary with their statements in the above mentioned interview.

Interview with RPN #124 indicated that PSW #133 did not report that the resident was agitated or resistive during care on an identified day, during a shift..

A review of the home's policy #RC 01-01-12, entitled, "Zero Tolerance to Resident Abuse and Neglect", dated August 1, 2010, indicated that the home have zero tolerance to any type of abuse and neglect of the residents.

A review of the home's investigation notes and an interview with the DOC-A indicated that they concluded that the allegation of abuse was not founded and the alleged staff member was removed from the resident's care based on the allegation made to the administrator.

Based on the pictures for the resident's intense impaired skin integrity, a significant change in the health condition and the resident's consistent statement to the family and Inspectors, the Inspector has warranted this non-compliance. [s. 19. (1)]

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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered staff, if clinically indicated.

The MOHLTC received a complaint from the SDM regarding altered skin integrity of resident #034.

Review of the resident's progress notes indicated on an identified day, resident #034 sustained an impaired skin integrity while being transferred.

A review of resident #034's assessment tab in PCC indicated a weekly skin assessment was completed on an identified day. Further review of the weekly skin assessments did not indicate further weekly skin assessments for the impaired skin integrity.

A review of the progress note made by RPN #126, indicated the impaired skin integrity was intact. When RPN #126 was asked if the impaired skin integrity was present when they wrote the progress note, the RPN indicated the impaired skin integrity was still present and healing well.

In interviews, RPNs #115 and #126 indicated that weekly skin assessments had to be

completed for an impaired skin integrity. The RPNs, reviewed the weekly skin assessments in PCC and indicated that weekly skin assessments were not completed for resident #034's impaired skin integrity.

In an interview, Clinical Manager (CM) #104 indicated that weekly skin assessments had not been completed for resident #034's, other than the initial assessment. [s. 50. (2) (b) (iv)]

2. Resident #002 triggered for altered skin integrity from stage one of the RQI.

A review of the resident's most recent written plan of care indicated the resident had a history of altered skin integrity on an identified body area and to assess the altered skin integrity weekly and notify the physician if the site worsens.

A review of resident #002's assessment tab indicated that weekly wound assessments were documented under the assessment tab in PCC. Further review of the weekly wound assessments indicated the resident had altered skin integrity on two identified body areas. Further review of the weekly wound assessments indicated the altered skin integrity on the two identified body areas were assessed only eight times during three months period and rest of the weeks, weekly assessments were not completed.

Interview with the CM and RN #113 confirmed that weekly wound assessments were not completed for the above mentioned time. According to the CM and RN #113, the altered skin integrity on one identified body area had deteriorated, when no weekly wound assessments were completed. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

According to O.Reg.79/10, s. 48 (2) a, each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols.

A review of the home's policy #02-05-06 titled, Skin integrity: risk assessment with a date of 2010, indicated that a Braden Scale Pressure Sore Risk Assessment (Braden) for Predicting Pressure Ulcers will be completed for all newly admitted residents, residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers and skin tears or wounds.

MOHLTC received a complaint from the SDM regarding altered skin integrity of resident #034.

Review of the resident's progress notes indicated, resident #034 sustained a, impaired skin integrity while being transferred out of bed to their wheelchair.

A review of resident #034's assessment tab in PCC indicated a Braden assessment was not completed upon discovery of the resident's impaired skin integrity on an identified day.

In interviews, RPNs #115 and #126 indicated that a Braden assessment had to be completed when a resident sustains an impaired skin integrity. The RPNs, reviewed the assessment tab in PCC and indicated that a Braden assessment had not been completed for the impaired skin integrity for resident #034 which was sustained on an identified day.

In an interview, CM #104 confirmed that a Braden assessment had not been completed for resident #034's skin tear as per home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 28th day of August, 2018

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

Original report signed by the inspector.