



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des Soins
de longue durée**

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

**Rapport d'inspection prévue
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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2018	2018_462600_0017	021928-17	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

GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): November 6, 7, 8, 13, 14, 15, 16, 19, 20, 21, 22, 26, 27, 28, 29, 30, and December 3, 2018.

During this inspection complaint log #021928-17, related to shortage of staff was inspected.

This inspection was conducted concurrently with complaint report #2018_751649_0022, for log #006654-18, related to shortage of staff, and complaint report #2018_462600_0016, for log #022093-18, for plan of care.

During the course of the inspection, the inspector(s) spoke with Corporate Director of Clinical Services, the Administrator, Administrative Director of Care (ADOC), Office Manager, Pay Roll Coordinator, Staffing Coordinator, Receptionist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Agency staff, and family members.

During the course of the inspection, the inspectors observed staffing deployment on the units, reviewed home's staffing plan, staffing schedule, master schedule, agency call-in records, agency staff sign-in records and relevant policy and procedures.

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

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:**s. 31. (3) The staffing plan must,**

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).

(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).

(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).

(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan:

(a) provided for a staffing mix that is consistent with residents' assessed care and safety needs, and

(c) promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident.

A complaint was submitted to the MOHLTC on an identified date regarding substitute decision maker (SDM)'s concerns of shortage of staff affecting residents' care, nursing and personal support services and administration of drugs.

A review of the home's staffing plan evaluated and revised on a specific date and confirmed by the home pay roll coordinator, indicated the home had four full time and eight part time open vacancies for PSWs and one full time and three part time open vacancies for registered staff. A review of the staffing plan evaluation for 2016 and 2017 indicated that the open vacancies were not addressed.

A review of the home's staffing record confirmed by the pay roll coordinator, indicated that the home had been working short of RN/RPN and PSW shifts in August; in



September, and in October, 2018.

In interviews with PSWs #119, #127, #128, #115, #129, and #130, RPNs #114 and #132, and RN #126, they confirmed that although the nurse in charge organize the work by priorities, the residents' care was still affected when they had to work short of staff as then they did not provide bathing to the residents scheduled to have a bath/shower, and those residents who needed mechanical lift for transfer from bed to a wheelchair by two staff, had been left in bed. The PSWs stated that when they were short of a PSW on the unit, the residents did not receive care on time, and most of the residents got upset because of the extended waiting time.

A review of the home's agencies staff usage records for months of August, September, and October 2018, confirmed by the pay roll coordinator, indicated that in August the home used an increased number of RN/RPN and PSW staff from different agencies, in September and in October, 2018.

An interview with the same RPNs indicated even when the home replaced the short shift with an agency staff, the RPN would assign the agency staff to "body" the regular PSWs. The RPNs clarified because the agency staff are not familiar with the residents' condition and needs, and there is no time for them to review all residents' written plans of care, they feel more safe to have the agency staff work with the regular PSW throughout the shift. The RPNs and the PSWs confirmed that because of the safety concerns, this added to their workload and further affected the provision of residents' care.

An interview with the Administrator and the pay roll coordinator confirmed that they are aware of the open vacancies, so they recruit monthly and hire on an ongoing basis, and also had contracted two additional nursing agencies to the existing one they had from August 2016. Further in the interview the Administrator indicated that the home had posted the vacancies, and hired the staff but the staff had been going either on a sick leave, leave of absence (LOA), or modified duties all the time, so the home constantly had open positions. The Administrator stated they thought they had done everything but were not able to keep all vacancies filled.

A review of the home's hiring plan indicated the home had a hiring job fair in February, August and November. A review of the staffing list indicated the home had seven staff on modified duty, and an identified number of RNs, RPNs, and PSWs on a casual basis working in the home.



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In an interview, the ADOC acknowledged that working short of staff, or using different staff members to provide nursing and personal care to the residents, had an impact on care of the residents and did not promote continuity of care. [s. 31. (3)]

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 staffing plan:

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs, and

(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, to be implemented voluntarily.

Issued on this 27th day of December, 2018

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

Original report signed by the inspector.