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 23, 2023	
Inspection Number: 2023-1452-0004	
Inspection Type: Critical Incident Follow up	
Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.	
Long Term Care Home and City: Villa Colombo Seniors Centre (Vaughan), Vaughan	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.10.25 10:21:32 -04'00'
Additional Inspector(s) Manish Patel (740841)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10, 12, 13 and 16-18, 2023

The following intake(s) were inspected:

- Intake #00092474/CI #2969-000024-23, intake #00086379/CI #2969-000014-23, intake #00089690/CI #2969-000019-23 and intake #00096475/CI #2969-000031-23 were related to Infection Prevention and Control (IPAC).
- Intake #00093276/CI # 2969-000027-23 was related to a fall of a resident with injury.
- Intake #00094691/CI #2969-000028-23 was related to staff to resident abuse.
- Intake #00098107/CI #2969-000036-23 was related to staff to resident abuse.

The following Compliance Order (CO) Follow up intake was inspected:

- Intake: #00094695 CO #001 under inspection # 2023-1452-0003; Duty to Protect - FLTCA, 2021 - s. 24 (1); Compliance Due Date September 29, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1452-0003 related to FLTCA, 2021, s. 24 (1) inspected by Maya Kuzmin (741674)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to implement strategies to reduce or mitigate the risk of falls and falls-related injuries for a resident.

One of the falls prevention and management program strategies required the staff to ensure that proper transfer as per assessed needs and plan of care is offered. Also, in accordance with FLTCA, 2021, s. 6 (7), the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Specifically, staff did not comply with providing assistance to transfer a resident as required by the care plan.

Rationale and Summary
The home submitted a Critical Incident (CI) regarding a resident who had an unwitnessed fall which resulted in injury, requiring hospital transfer.

Upon readmission from hospital, the resident's care plan was updated to include two-persons extensive physical assistance with the use of walker for additional support during transfers. On a later date, the resident's transfer was changed to assistance of one person.

Upon documentation review during the time frame when the resident required assistance of two-

person for transfers, it was noted that the resident was transferred with assistance of one person, multiple times during day and evening shifts during two particular months.

A direct care staff acknowledged that the resident was transferred with assistance of one person. Director of Care (DOC) stated that the care plan was not followed.

Failure to not follow the resident's care plan related to transferring increased the risk of falls and injuries to the resident.

Sources
Resident's clinical records; falls prevention and management program policy #05-02-02; Interview with staff.
[740841]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that symptoms indicating the presence of infection were monitored for a resident, in accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes.

The Infection Prevention and Control Lead (IPAC lead) failed to ensure that they employed syndromic surveillance regularly to monitor for symptoms, including but not limited to, fever new coughs, nausea, vomiting, and diarrhea, and taking appropriate action in accordance with the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard).

Specifically the IPAC lead did not ensure that symptoms indicating presence of infection were monitored for a resident on a specific date, as is required by the Additional Requirement under 3.1 (i) under the IPAC Standard.

Rationale and Summary:

A resident was documented to have an infection on the home's line listing and was provided with treatment.

A registered staff verified that they did not complete the Daily Infection Signs and Symptoms Tracking

Form or document symptom surveillance of the resident's infection. IPAC lead indicated that the expectation related to monitoring symptoms indicating the presence of infection for a resident involved two components. The first required the staff to document when the resident's symptoms began on the line list. Once the resident was indicated on the line list, their symptoms were to be monitored every shift by staff. The second component, involved the staff documenting in the resident's progress notes.

Failure to follow the directions related to monitoring the resident's presence of infection as specified in the IPAC Standard may have contributed to the late detection and treatment of symptoms.

Sources: Resident's progress notes; Daily Infection Signs and Symptoms Tracking Form; interviews with staff.

[741674]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the written responses provided to a person who made a complaint to the licensee concerning the care of a resident, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A written complaint regarding care of a resident was received by the licensee and the complaint was provided a response in writing.

The DOC acknowledged that the response letters did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Sources
Review of the response letter; and Interview with DOC.

[740841]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.

The licensee has failed to ensure that the written responses provided to a person who made a complaint to the licensee concerning the care of a resident included confirmation that the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Fixing Long-Term Care Act (FLTCA) and had done so.

Rationale and Summary
A written complaint regarding care of a resident was received by the licensee and the complaint was provided a response in writing.

The DOC acknowledged that the response letters did not include confirmation that the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the FLTCA.

Sources
Review of the response letter; and Interview with DOC.

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