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
Jul 17, 2018	2018_654618_0014	012094-17, 016539-17, 018464-17, 023487-17, 023643-17, 025433-17, 000217-18, 000792-18	Complaint

Licensee/Titulaire de permis

Villa Colombo Homes for the Aged Inc.
40 Playfair Avenue TORONTO ON M6B 2P9

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

Villa Colombo Homes for the Aged
40 Playfair Avenue TORONTO ON M6B 2P9

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

CECILIA FULTON (618)

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): May 23, 23, 24, 28, 29, 31 and June 1, 4, 5, 2018.

The following complaint logs were inspected:
Related to Plan of care: 000792-17, 023643-17, 018464-17, 016539-17
Related to Skin and Wound: 023487-17
Related to Nutrition and Hydration: 012094-17
Related to Continence Care: 023643-17

During the course of the inspection, the inspector(s) spoke with the Director of Resident Services, Registered Nurses (RN), Register Practical Nurses (RPN), Personal support worker (PSW), Substitute decision makers (SDM) and Residents.

During the course of the inspection, the inspector reviewed clinical records including plans of care, Medication Administration Records, assessments and the homes investigation notes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This inspection was initiated to inspect issues identified in a complaint. The complainant was not able to be reached for a pre-inspection discussion of the issues documented in the complaint log.

Record review revealed discussions which occurred in June 2017, between the family and the staff of the home regarding care issues.

A progress note, dated in June 2017, revealed that the family of an identified resident had a discussion with the home and one of the issues of concern was that the resident was not getting their scheduled bathing.

Review of the bath record revealed that there was no documentation for bathing during a 12 day period in June 2017.

A progress note dated in June 2017, also documented the absence of a bathing for the same 12 day period in June 2017.

A progress note dated in June 2017, stated that the resident was not bathed during the identified shift, and confirmed that their bathing was scheduled to take place on identified days and shifts.

Interview with PSWs indicated that bathing of residents should occur on scheduled days and shifts, and if for some reason bathing cannot occur as scheduled, this information should be passed onto the next shift. PSWs indicated that information related to bathing should be documented in the care flow sheet and also the bath/skin assessment sheet.

Interview with the Director of Resident Services confirmed that the resident did not receive care as set out in the plan of care. [s. 6. (7)]

Issued on this 21st day of August, 2018

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

Original report signed by the inspector.