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 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
Nov 3, 2018	2018_634513_0013	008792-17, 022433-17, 009138-18, 014340-18, 015696-18	Critical Incident System

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

JUDITH HART (513), JOANNA WHITE (727)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 2, 3, 4, 5, 9, 10, 11, and 12, 2018.

During this inspection the following intakes were inspected: intake log #014340-18 for Critical Incident System (CIS) report #C577-000039-18, log # 015696-18 for CIS report #577-000040-18, related to a resident fall, and intake log #008792-17 for CIS report #577-000037-17, related to possible neglect.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DRC), Director, Nursing Unit Third Floor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Service Workers (PSW), residents and family members.

During the course of the inspection, the inspectors conducted observations in resident areas, observation of care delivery processes including the ambulation of residents, reviewed residents' health records, the home's policies and procedures and falls prevention and management program.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) A Critical Incident System (CIS) report was received by the Ministry of Health and Long-Term Care MOHLTC), which indicated resident #011 was currently in hospital after an alteration in mobility on a specified date. The resident sustained an injury, was hospitalized, subsequently returned to the home and passed away on a specified date.

In accordance with O. Reg 79/10 r. 49 (1), every licensee of a long-term care home shall ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimens, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A review of resident #011's progress notes indicated the resident had several falls on specified dates in 2018, and on an additional specified date in 2018 the resident had an alteration in mobility, sustained an injury, was transported to hospital and was diagnosed with a specific medical condition. The resident returned to the home and subsequently died on a specified date.

A review of the written care plans of specified dates indicated the resident was at a high risk for alteration in mobility. The resident was living with a progressive decline in intellectual functioning, which contributed to specified responses and required extensive one-person assistance with activities of daily living. The resident required supervision for specific activities and walked independently with a specific mobility device.

A review of the home's policy titled, Head Injury Routine (HIR), reviewed August 2015, stated that for any resident who has experienced a blow to the head from any form or trauma sustained, staff should initiate a HIR every 15 minutes for the first hour, every 30 minutes for the second hour, every hour for four hours, then every four hours for 72 hours. Further, the policy stated assessment of the injury must include the following information on the HIR record, but not limited to: vital signs, level of consciousness, response to painful stimuli or command, pupil reaction, pain and so forth.

A review of the HIR assessment records for resident #011, indicated the HIR had not been documented as completed on eight specified dates.

An interview with the Director, Nursing Unit third floor and Lead for Falls Prevention stated staff were expected to follow the home's policy and that the HIR routine should be followed. The Director further stated resident #011's HIR had not been documented on the HIR form, in the progress notes, nor in the vital signs record for the aforementioned dates and times.

An interview with the Director of Resident Care (DRC) stated that staff were expected to follow the home's policy and document the HIR assessments at the appointed dates and times for resident #011, and did not, therefore not adhering to the home's policy.

b) The resident sample was expanded to three residents who had sustained falls.

A critical incident report was received by the MOHLTC, indicating that resident #002 had an alteration in mobility and sustained an injury.

A review of the progress notes for a three and a half month period in 2018, identified resident #002 had an alteration in mobility on six specified dates. The alteration in mobility on one of the specified dates resulted in an identified injury, which required medical treatment.

A review of the care plan of a specific date in 2018, identified the resident had a progressive decline in intellectual functioning and was at a high risk for an alteration in mobility.

A review of the HIR records for resident #002 identified incomplete HIR documentation on four specific dates and times in 2018.

An interview with the Director, Nursing Unit Third Floor and Lead for Falls Prevention stated staff were expected to follow the home's policy and that the HIR assessment routine should be documented by staff at the appointed dates and times for resident #002, and did not, therefore not meeting the home's policy.

c) A CIS report was received by the MOHLTC in 2017, which indicated resident #003 had an alteration in mobility, sustained an injury and was transferred to hospital.

A record review of the progress notes identified resident #003 had an alteration in mobility on a specific date in 2017, and sustained an injury.

A review of the care plan on a specified date identified resident #003 had a chronic progressive decline in intellectual functioning and was at a high risk for alteration in mobility.

A review of the HIR records for resident #003 identified incomplete HIR documentation on specific dates and times in 2017.

An interview with the Director, Nursing Unit Third Floor and Lead for Falls Prevention stated staff were expected to follow the home's policy and that the HIR assessment should be documented by staff at the appointed dates and times for resident #003, and were not, therefore not adhering to the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, and is complied with, to be implemented voluntarily.

WN #2: 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

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.

The following is further evidence to support the order issued on October 10, 2018, during complaint inspection 2018_634513_0009, to be complied December 7, 2018.

a) A CIS report was received by the MOHLTC in 2018, which indicated resident #011 was currently in hospital after an alteration in mobility on a specified date. The resident sustained an injury, was hospitalized, subsequently returned to the home and passed away on a specified date.

A review of the written care plans from specified dates indicated the resident was at a high risk for alteration in mobility. The resident was living with a progressive decline in intellectual functioning, which contributed to specified responses and required extensive one-person assistance with activities of daily living. The resident required supervision for specific activities and walked independently with a specific mobility device.

The written care plan on a specified date indicated staff were to escort resident #011 to and from the dining room and activities.

An interview with PSW #102, who was the caregiver for the resident on a specific date in 2018, stated at 1300h they did not escort resident #011 from the dining room as they were attending to another resident in their room. An interview with RN #101 identified

they could not confirm that resident #011 was escorted from the dining room on the above mentioned date at the specified times.

An interview with the Director, Nursing Unit Third Floor and Lead for Falls Prevention confirmed resident #011 was likely not escorted from the dining room on the specific date at the specified times.

An interview with the Director of Resident Care (DRC) confirmed that when care interventions are identified in the care plan for resident #011 they should be followed as specified in the plan.

b) A CIS report received by the MOHLTC, in 2018, indicated that resident #002 had an alteration in mobility and sustained a specific injury.

A review of the progress notes for a three and a half month period in 2018, identified resident #002 had an alteration in mobility on six specified dates. The alteration in mobility on one of the specified dates resulted in an identified injury, which required medical treatment.

A review of the written care plan on a specified date in 2018, identified resident #002 was at a high risk for an alteration in mobility and had progressive decline in intellectual functioning. The resident required two-person extensive assistance with transfers.

Observations by Inspector #727 on a specified date at a specific time identified resident #002 being assisted with one-person assistance.

Interviews with PSWs #107, #108 and #111 stated and confirmed resident #002 should have two persons assist during mobility activities as per the current care plan.

An interview with the Director, Nursing Unit Third Floor acknowledged resident #002 was to be transferred with the assistance of two staff and in this instance the care set out in the plan of care was not provided to resident #002 as specified in the plan. [s. 6. (7)] [s. 6. (7)]

2. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care, if the plan of care is being revised because care set out it the plan had not been effective.

A CIS report on a specific date in 2018, indicated that resident #011 was currently in hospital after an alteration in mobility on a specific date in 2018. The resident sustained a specific injury, was hospitalized, subsequently returned to the home and passed away on a specific date in 2018.

A review of the written care plans of specified dates indicated the resident was at a high risk for alteration in mobility. The resident was living with a progressive decline in intellectual functioning, which contributed to specified responses and required extensive one-person assistance with activities of daily living. The resident required supervision for specific activities and walked independently with a specific mobility device.

A review of the written care plans following each of the resident #011's falls on specified dates in 2018, indicated the care plan for the resident was not revised following each of the alterations in mobility.

An interview with the Director, Nursing Unit third floor and Lead for Falls Prevention stated the identified care plans were not revised following each of resident #011's alterations in mobility on the above mentioned dates. The DRC confirmed that when resident #011 had alterations in mobility and the plan of care was not effective, different approaches were to be considered and the care plan was to be revised. [s. 6. (11) (b)]

Issued on this 30th day of November, 2018

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

Original report signed by the inspector.