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
Feb 21, 2019	2019_631210_0001	011931-18, 029035-18, 029037-18, 029241-18, 000622-19, 001436-19	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

SLAVICA VUCKO (210)

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): January 11, 15, 16, 17, 18, 21, 22, 23, 24, 25, 30, 31, and February 1, 2019.

During the course of the inspection, the following Critical Incident intakes were inspected:
-Intake log #011931-18 related to falls prevention management;
-Intake log #00622-19, related to hospitalization and injury of unknown cause and related complaint log #001436-19.

During the course of the inspection the following follow up intakes were inspected:
-Intake Log #029037-18 related to prevention of abuse,
-Intake Log #029035-18 related to minimizing the risk of altercation,
-Intake Log #029241-18 related to falls prevention management.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Director of Nursing Care (DONC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), Occupational Therapist (OT) and Physiotherapist (PT).

The inspector performed observations of staff and resident interactions, provisions of care, reviewed residents' clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2018_654618_0015	210
O.Reg 79/10 s. 54.	CO #001	2018_654618_0015	210
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_634513_0009	210

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and compliment each other.

A Critical Incident System (CIS) report and a complaint by a family member was sent to the Ministry of Health and Long Term Care (MOHLTC) related to an injury of unknown cause for which the resident was taken to hospital and which resulted in significant change in the resident's health status.

A review of resident #005's incident notes indicated that on a specified date and time PSW #110 tried to transfer resident #005 from their wheelchair to bed and the resident was not able to weight bear. The resident complained of pain on a part of their body. When RPN #115 assessed the resident they noted abnormality on the above mentioned part of the body. The resident was transferred to hospital, diagnosed with body injury and underwent surgery.

A review of resident #005's written care plan indicated they required one staff assistance with activity of daily living, and the resident was at high risk for falls. On a specified date, the written care plan was updated that the resident started using a loaner wheelchair until further assessment by Physiotherapist (PT) and Occupational Therapist (OT). The resident to be monitored every hour for safety.

A review of the progress notes and interview with the OT indicated the resident was

assessed for a regular wheelchair on a specified date, and a tilt wheelchair on a later date. The OT documented that the resident had not demonstrated any ability to self-propel the wheelchair due to health condition, the tilt mechanism to be disabled at that time as the client did not require it; tilt option will be beneficial in the long term as client has a progressive diagnosis. The Substitute Decision Maker (SDM) had requested for a tilt wheelchair at the present time so that they don't need to purchase another wheelchair in the future when client's condition deteriorates. Interview with the OT indicated they notified the wheelchair supplying company to disable the tilt mechanism on the wheelchair right after they spoke with the family member.

Interview with PSW #108 indicated that on a specified date and time, the resident was placed in bed. Interview with PSW #118 indicated at a later time they responded to resident #005's bed alarm and noted the resident standing by the room door, in the bedroom. The resident was transferred to their wheelchair and placed at the nursing station for close monitoring. Later the resident continued to be restless and was attempting to move their legs in the wheelchair.

Review of the PT notes indicated on a specified date, resident #005 was resting in their wheelchair. On two later specified dates, resident #005 was found resting in a tilt wheelchair, before the physiotherapy program. Interview with the PT confirmed that the documentation described the position of the resident when in their wheelchair and that the resident was tilted.

Interview with PSW #108 indicated that during an identified shift on the above specified date, resident #005 was restless in the wheelchair and trying to get up. PSW #110 indicated that later on the above mentioned date, the resident's wheelchair was slightly tilted. RPN #115 documented that during the above mentioned shift, the resident was noted as being uncomfortable while in their wheelchair.

A review of resident #005's written care plan indicated that it was updated on a specified date, that the resident used loaner wheelchair until further assessment by the OT. The resident to be monitored every hour for safety. It did not mention that the wheelchair tilt mechanism should be disabled as per the OT's assessment documented in the progress notes as mentioned above.

Interview with the OT indicated that the wheelchair supplier company required a couple of weeks notice to disable the tilt feature on wheelchairs. They confirmed that the company provided a permanent wheelchair to the resident on a specified date, and it was

not locked. The OT further indicated that they discussed with registered staff about disabling the tilt feature of the wheelchair until further assessment, but they were not able to recall which staff they had the discussion with.

Observation on a specified date and time and interview with OT and DON #109 confirmed resident's wheelchair was not disabled for the tilting feature on the wheelchair.

Interview with DON #109 indicated that the expectation was that registered staff should update the written care plan as per the recommendations of the OT and acknowledged that it was not done for resident #005. [s. 6. (4) (a)]

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

A CIS report was submitted to the MOHLTC related to an incident that caused an injury to resident #006 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of resident #006's clinical record indicated that on a specified date and time PSW #103 found the resident on the floor in their room with severe pain in part of the body. RPN #102 assessed the resident, and transferred them to hospital for further treatment. The resident underwent surgery to the part of the body. Interview with PSW #106 who worked the shift before the fall indicated that a fall intervention was not in place when the resident was in bed. During interviews with PSW #103 and RPN #102 they were not able to confirm if the fall intervention was implemented at the time of the fall.

A review of resident #006's falls risk assessments indicated that the resident was at high risk for falls. They had three falls in one year.

A review of resident #006's written care plan in place prior to the fall mentioned above, indicated interventions to prevent falls such as toileting every one to two hours, walker for ambulation all the time, bed sensor pad, call bell to be clipped to resident's clothing when in bed and encourage resident to use call bell when help is required, non slip footwear, bed in lowest position and floor mat whenever resident is in bed.

Interview with PSW #103 indicated the resident never used the call bell to call staff for help, but staff had to attend the resident every one to two hours for toileting. After the

resident fell on the above mentioned date, use of an identified fall intervention was implemented and they were moved to another room closer to the nursing station. Interview with PSW #106 indicated unawareness that resident was at high risk for falls and that they had previous falls.

Interview with the DOC indicated the expectation was the resident's care to be provided as per the written plan of care. Interviews with RPN #102, PSW #103 and PSW #106 were not able to confirm that resident #006 had the above mentioned identified fall intervention in place on a specified date, as per the plan of care. [s. 6. (7)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and compliment each other, the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 25th day of February, 2019

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

Original report signed by the inspector.