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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Nov 25, 2019	2019_804600_0021	025310-18	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

GORDANA KRSTEVSKA (600)

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): October 2, 3, 4, 8, 9, 10, 21, 22, 23, 24, 25, 28, 2019.

**The following intakes were completed in this Complaint Inspection:
#025310-18, regarding hospitalization and change in a condition.**

During the course of the inspection, the inspector(s) spoke with the Director of Resident Services (DRS), Attending Physician (MD), Director of Nursing Unit (DNU), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Maker (SDM) and residents.

During the course of the inspection, the inspectors conducted observations of the home including resident home areas, the provision of resident's care, staff to resident interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

**The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control**

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that substitute decision maker of resident #001 was given the opportunity to participate fully in the development and implementation of resident #001's plan of care.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) on an identified date, regarding a substitute decision maker (SDM)’s concerns about resident #001, who passed away in a hospital after they were transferred from a long-term care (LTC) home after admission.

An interview with the SDM indicated that when they took the resident from their private residence to the LTC home, the resident was walking and independent with their activities of daily living (ADLs). After a few weeks, the resident was sent to hospital due to change in their condition and a few days later, the resident passed away. Further the SDM indicated that the resident lived alone, and they would assist them with follow up appointments to the family physician and prescriptions as needed. The SDM stated that the resident's condition started to change while at home and were not taking their medications. The resident was admitted to the LTC home under "crisis" placement, because their condition was deteriorating rapidly. The SDM indicated one of their concerns was related to the medications that the resident had not received during the time they resided in the LTC home, and that they found out after the resident passed away. The other concern was related to the resident being sent to the hospital for experiencing an episode of health problem, as it was one of the resident's known chronic conditions.

A review of resident #001's admission record and progress notes for the short stay in the LTC home indicated that the resident arrived in the home with their SDM who was present during the admission process. The SDM had been contacting the home frequently, and getting updates regarding the resident's condition.

An interview with Registered Practical Nurse (RPN) #130 indicated that they had not administered medications to resident #001 for the time they resided in the home because they did not have any order for medications. The RPN said the resident's condition had been stable until the day that they were found with changed health condition, then sent to hospital. The RPN indicated they contacted the SDM when the resident was hospitalized and was told that the resident had chronic change of the condition and had been prescribed medications for the condition from their family physician while living at home. The RPN also said that the SDM shared that the resident had exhibited the same clinical symptoms as mentioned above, many times before coming into the LTC home, and the

family would just stay with the resident until they return to their usual condition; they would not transfer them to hospital. The RPN indicated that the SDM had informed them that the resident was not taking their medications at home because of change in condition, which was one reason they admitted the resident to the LTC home, to have ongoing support, and reminders to take their medications. The RPN confirmed that none of the resident's health history as mentioned by the SDM above or medication, except the medical diagnosis were in resident #001's clinical record or plan of care.

In an interview, RPN #126 stated they admitted resident #001 into the home and followed the home's admission checklist. They indicated that upon admission the SDM told the RPN that the resident did not take any medication, however the RPN requested the SDM check and bring all medications that the resident had at their home. They stated that the SDM had never told the nurse to hold or discontinue any medication. RPN #126 further stated once they finished the admission interview with the resident and the SDM they reviewed the resident's Local Health Information Network (LHIN) record and found a medication list and the prescription from the pharmacy. They completed the medication reconciliation, notified the attending physician (MD) who discontinued all the medications based on the RPN's information received from the SDM, and faxed it to the pharmacy the same afternoon. The RPN stated that they did not ask the SDM about the resident's health history and did not follow up with them if they brought medications from the resident's home. The RPN further confirmed that they were not aware that the resident did not take medications because of their changed condition, and they did not clarify with the SDM if the medications listed in the resident's LHIN record were current medications. The RPN also confirmed that they did not communicate with the SDM when the physician had discontinued the resident's medications.

In an interview, the MD indicated that they visit the home every Thursday to assess residents. If they are not present when a resident was admitted into the home, they rely on the information provided by the registered staff and make decisions about the medications. The next visit when the MD comes to the home, they assess the resident and review their decisions about medication treatment including the resident or the SDM. The MD stated that they were not in the home when resident #001 was admitted, so they discontinued their medication as per information received by the nurse; they planned to assess the resident the following visit. The MD did not visit the home the following week, so the resident was not assessed by MD until two weeks after admission. On the next MD visit, they assessed the resident in the morning, did not identify any concern regarding the resident's health issue, and prescribed medications to maintain the resident's health. The MD also stated they did not communicate with the SDM, as there

was no concern identified by the staff for the two weeks of resident #001 being in the home.

In an interview, the Director of Resident Services (DRS) said the home had designated Registered Nurses (RN) to conduct the admission process and they were expected to follow the home's admission checklist. The DRS acknowledged that in this case, RPN #130, who was conducting the admission process instead of an RN, did not collect the history from the SDM about the resident's health condition, and the SDM was not involved in the plan of care for resident #001 related resident #001's health condition and medications assessment. [s. 6. (5)]

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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: 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 where the Act or this Regulation required the

licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, it was complied.

In accordance with LTCHA 2017, c.8. r. 8 (1) (b) and in reference to O. Reg. s. 114. (2) where the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the staff did not comply with the licensee's policy Medication Reconciliation #RC-16-01-11, last updated February 2017 as part of the medication Management Policy which described the process of medication reconciliation on admission.

A complaint was submitted to the MLTC on an identified date, regarding SDM’s concerns about resident #001 who passed away in hospital after they were transferred from a long-term care home two weeks after admission. The resident had not received their medications during the time in the home.

An interview with the SDM indicated that when they took the resident from their private residence to the LTC home, the resident was walking and independent with their ADLs. After two weeks, the resident was sent to hospital due to change in a condition and few days later, the resident passed away. Further the SDM indicated that the resident lived alone, and they would assist them with follow up appointments to the family physician and prescriptions as needed. The SDM stated that the resident's condition started to change while at home and were not taking their medications. The resident was admitted to the LTC home under "crisis" placement, because their condition was deteriorating rapidly. The SDM indicated one of their concerns was related to the medications that the resident had not received for the time they resided in the LTC home, that they found out after the resident passed away in hospital. Further in the interview the SDM indicated that the day after their parent was admitted in the LTC home, they brought the medications that the resident had at their home. They showed the medications to one of the registered staff, but the nurse told them that they should take the medications back home. The nurse who completed the admission record will contact the pharmacy and obtain the resident’s prescribed medication list, so the resident will start the medications the next day. The SDM stated that no one had ever asked them or brought to their attention that the resident did not receive the medications while in the LTC home.

A review of resident #001's LHIN assessment record dated January 10, 2017, indicated that the resident had identified medical conditions. The resident had not taken their

medications despite experiencing identified health problems. A current medication list from the LHIN record indicated that the resident was billed for identified medications a few days prior to admission in the home.

A review of the resident's Medication Administration Record (MAR) for an identified month, indicated that the resident was not on any medication.

Review of the home's policy titled Medication Reconciliation #RC-16-01-11, last updated February 2017, stated that medications reconciliation will be completed for all residents on admission, transfer and discharge to prevent medication errors, ensure safe medication administration practice and to prevent/decrease adverse drug events. A best possible medication history will be completed within 24 hours of admission and reconciled within 72 hours of admission. Further, the policy guided the staff in the procedure of the medication reconciliation. Under section #1. a. the Policy stated: A systematic process of the interviewing the resident, POA, SDM/family and b. a review of at least one other reliable source of information. Under section #4. the policy says to document and communicate any resulting changes in medication orders to the physician, Nurse Practitioner (NP), resident, power of attorney (POA), SDM, family.

Under the home's pharmacy Medication Reconciliation policy #MEDI-CL-ONT-038 Issue dated October, 2018, define the BPMH (Best possible Medical History) as a current medication history obtained by a health care professional which includes a through history of all regular medication use (prescribed and not prescribed) using some or all of the following sources of information: resident or caregiver interview; inspection of vials and other medication containers, review of the personal medication list, and or follow up with a community pharmacy or review of a current medication list. This list must include both prescription and over-the counter medication, and most recent list of the medication dose, route, and frequency currently taken by the resident. The process of the medication reconciliation involves interviewing the resident, family, or caregivers, and consulting at least one additional source of information (resident's previous MAR, community pharmacy profile, prescription vials or bottles.)

In an interview, RPN #126 stated they admitted resident #001 into the home and completed the admission checklist. The RPN indicated that upon admission the SDM told the RPN that the resident did not take any medication, however the RPN requested the SDM check and bring any medication that the resident had at their home. They stated that the SDM had never told the nurse to hold or discontinue any medications. RPN #126 further stated once they finished the admission interview with the resident and the

SDM they reviewed the resident's LHIN record and found the medication list and the prescription from the pharmacy. They completed the medication reconciliation, notified the attending physician (MD) who discontinued the medications based on the information received by the RPN from the SDM, and faxed it to the pharmacy that afternoon. The interview with RPN #126 confirmed that they:
- did not follow up with the SDM who brought the medications from the resident's home,
- did not ask the SDM about the resident's health history, so they were not aware that the resident did not take medication because of change of condition,
- did not clarify with the SDM the medications listed as current medication in the resident's LHIN record,
- did not communicate with the SDM when the physician discontinued the resident's medications, and
- did not document the admission and medication reconciliation process to communicate any resulting changes to the rest of the team.

An interview with the DRS indicated that staff are expected to follow the home's medication reconciliation policy for newly admitted residents. During the interview, the inspector reviewed the home's policy and pharmacy manual with the DRS. The DRS acknowledged that the RPN did not follow the policy which guided the staff to a systematic process of interviewing the SDM, and for the best possible medication history to be completed within 24 hours of admission, and reconciled within 72 hours of admission. The DRS also acknowledged that the RPN completed resident #001's medication history and faxed to the pharmacy but did not notify the SDM regarding the discontinued medication. They also acknowledged that the RPN failed to document and communicate any resulting changes in medication orders to the team including the SDM. [s. 8. (1)]

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 where the Act or this Regulation required 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 was based on an interdisciplinary assessment with respect to the resident's disease diagnosis.

A complaint was submitted to the MLTC on an identified date, regarding SDM's concerns about resident #001 who passed away in a hospital after they were transferred from a long-term care home two weeks after admission.

An interview with the SDM indicated that when they took the resident from their private residence to the LTC home, the resident was walking and independent with their ADLs. After two weeks, the resident was sent to hospital due to change of a condition and a few days later, the resident passed away. Further the SDM indicated that the resident lived alone, and they would assist them with follow up appointments to the family physician and prescriptions as needed. The SDM stated that the resident's condition started to change while at home and were not taking their medications. The resident was admitted to the LTC home under "crisis" placement, because their condition was deteriorating rapidly. The SDM indicated one of their concerns was related to the medications that the resident had not received for two weeks while they resided in the LTC home, that they

found out after the resident passed away in hospital. The other concern was related to the resident being sent to the hospital for experiencing an episode of health problem, as it was one of the resident's known chronic conditions.

A review of resident #001's LHIN assessment record from an identified date indicated that the resident had medical condition. They had not taken their medications despite experiencing identified health problems. A current medication list from the LHIN record indicated that the resident was billed for identified medications a few days prior to admission in the home.

A review of the resident's health record indicated that the resident was admitted into the home on a specified date, with the above identified medical diagnosis. A review of resident #001's admission record indicated that the SDM was present during the admission process and had communicated with the staff, and getting updates on the resident's condition frequently.

A review of the resident's laboratory test results indicated that the resident had blood work done on an identified date with results from the lab work indicating the status of the health condition. A review of the resident's plan of care indicated no specific treatment was planned or implemented to resident #001 related to the identified medical condition. The results were reviewed by the physician and initialled when the resident was sent to hospital.

An interview with RPN #130 indicated that they had not given any medication to resident #001 for the time they resided in the home because they did not have order for any medication. The RPN said the resident's condition had been stable until the day when they found the resident with changed condition and sent them to hospital. They indicated they contacted the SDM to notify them about the hospitalization, and they understood that the resident had the health problem and had been prescribed medication from their family physician before.

In an interview, RPN #126 stated they admitted resident #001 into the home and completed the admission checklist. The RPN indicated that upon admission the SDM told the RPN the resident did not take any medication, but they did not ask the SDM about resident #001's health history; they were not aware that the resident had chronic health problem and was not taking their medications because they had health condition changed.

In an interview, the MD indicated that they were not present when resident #001 was admitted in the home, so they relied on the information provided by the registered staff about the resident and their condition, when they made decisions about the medications. The next visit the resident was not seen by the MD as the MD missed their visit in the home. The resident was assessed by the MD two weeks after; they did not identify any concern regarding the resident's health issue, so they prescribed medications to maintain the resident's health. The MD also stated that the same afternoon, the resident's condition changed, and they sent the resident to hospital. The MD confirmed that if they knew the resident's health condition and history, they would have ordered medications for the resident on admission.

In an interview, the DOC acknowledged that resident #001 was admitted in the home in a compromised health condition and should have been provided medication treatment for the medical condition they had. [s. 26. (3) 9.]

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 plan of care for resident is based on an interdisciplinary assessment with respect to the resident's disease diagnosis, to be implemented voluntarily.

Issued on this 26th day of November, 2019

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

Original report signed by the inspector.