Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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 24, 2020	2020_751649_0003	019746-19, 020640-19, 022037-19, 022359-19, 023141-19	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

JULIEANN HING (649)

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): Februay 11, 12, 13, and 14, 2020.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
Logs #020640-19/ Critical Incident System (CIS) #C577-000059-19, #022359-19/ CIS #C577-000063-19, and log #022037-19/ CIS #577-000062-19 related to plan of care.
Logs #019746-19/ CIS #C577-000055-19 and #023141-19/ CIS #C577-000065-19 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the director resident services (DRS), registered nurse (RN), registered practical nurses (RPNs), personal support workers (PSWs), and residents.

During the course of this inspection non-compliance was identified under s. 6. (7) of the Long-Term Care Homes Act, 2007 (LTCHA, 2007).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

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	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. (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 resident #014 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to a resident missing.

Further review of the CIS report indicated that resident #014 was last seen on an identified date and time walking out of the home's back door entrance near the parking lot, when a co-resident's family member had entered the home according to the home's camera footage. The resident returned to the home on the same day approximately eight hours later accompanied by police unharmed.

A review of the resident’s care plan indicated the use of an identified device for risk of elopement.

A review of progress notes indicated resident #014 had a history of removing the identified device and staff would often find it in the garbage.

In an interview with RPN #102, they confirmed that resident #014 had not been wearing the identified device on the day of this elopement. They had been informed of this by the PSW, and confirmed that the plan of care had not been followed.

In an interview with DRS #104, they acknowledged that resident #014’s plan of care had not been followed as they were not wearing the identified device on the day they had eloped from the home.

Review of the home's Compliance History revealed a history of non-compliance related to the LTCHA, 2007, s. 6. (7). An order was issued under s. 6. (7) during inspection report # 2019_804600_0022 dated November 25, 2019, with a compliance due date of April 16, 2020. [s. 6. (7)]. A written notice (WN) has been issued under s. 6. (7) with additional evidence for the existing order not past-due.

Issued on this 28th day of February, 2020

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

Original report signed by the inspector.