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

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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
Sep 2, 2020	2020_767643_0016	014307-20, 015719-20, 016905-20	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

ADAM DICKEY (643)

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): August 14, 17-20 and 25, 2020.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Logs #014307-20, CIS #3020-000009-20; and #016905-20, CIS #3020-000014-20 - related to unexpected or sudden deaths; and
Log #015719-20, CIS #3020-000011-20 - related to fracture of unknown origin.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Services, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection the Inspector conducted observations of staff and resident interactions and the provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of the unexpected or sudden death of a resident.

A Critical Incident system (CIS) report was submitted to the Director of the Ministry of Long-Term Care on an identified date. Review of the CIS report showed that on the previous day, a resident was found on the floor, became unresponsive and a medical emergency code was announced in the home. The resident was pronounced dead following cardiopulmonary resuscitation attempts. No after-hours report was found relating to this incident.

In an interview, the Director of Resident Services (DRS) indicated that they were aware of the requirement for incidents of an unexpected or sudden death of a resident are to be reported to the Director immediately. The DRS indicated that they had attended the unit in which the above resident was found unresponsive, reviewed the situation and debriefed staff on the day of the incident. The DRS indicated they normally made sure to report to the Director immediately any unexpected or sudden death of a resident and was not sure why it had not been reported until the following day. [s. 107. (1) 2.]

Issued on this 8th day of September, 2020

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

Original report signed by the inspector.