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_0017	011697-20	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

ADAM DICKEY (643)

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

The following complaint intake was inspected during this inspection:
Log #011697-20 - related to Infection Prevention and Control and End-of-Life Care.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Services, Directors of Nursing, Nurse Practitioner (NP), Infection Control lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and resident family members.

During the course of the inspection the Inspector conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, infection symptoms monitoring documentation, outbreak surveillance documentation and relevant policies and procedures.

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

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)**

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. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 received end-of-life care in a manner that met their needs.

A complaint was received by the Ministry of Long-Term Care regarding the care of

resident #011 during the COVID-19 outbreak in the home. Resident #011's family member indicated they were approached by RPN #109, who indicated that they were going to administer medication to the resident which should have been administered earlier in the day. The complainant indicated that there was some confusion between members of the registered staff, and that RPN #109 indicated RN #110 should have administered the medication earlier in the shift.

Review of resident #011's progress notes showed that on an identified date, the resident was found to be moaning and in respiratory distress on an identified shift and was given as needed (PRN) medications with effect; noting the Nurse Practitioner (NP) was to be informed of the resident's status. The progress notes further showed that RN #110 assessed the resident, noting the resident was moaning, with laboured breathing and shortness of breath (SOB). NP #114 assessed the resident and indicated to administer palliative medications as per the physician's orders, and to call the family to inform them of the resident's imminent passing. Approximately five hours after RN #110 assessed the resident, RPN #109 consulted with NP #114 and administered an identified PRN medication for SOB and respiratory distress, which was effective in settling the resident.

Review of Physician's Digiorder sheet for resident #011 showed that on the above identified date, a telephone order was obtained from the physician, and co-signed by RN #110 for the above identified medication, every 2 hours PRN for SOB or discomfort. Review of resident #011's electronic medication administration record (eMAR) showed RPN #109 administered the medication approximately 5 hours after the assessment by RN #110.

In an interview, RPN #109 indicated that when they began their shift on the identified date, they noted resident #011 in distress. The RPN indicated that they asked for the NP to come and assess the resident for palliative care, and asked RN #110 to care for the resident. RPN #109 indicated they had told RN #110 that the resident was in distress and the RN took over. RPN #109 indicated that RN #110 did not administer the above identified PRN medication for resident #011 when they were showing signs of distress, and didn't properly care for the resident. RPN #109 indicated they again consulted with NP #114 and asked the NP if it was okay to administer the medication for resident #011, as they were in respiratory distress over the last several hours; they administered the medication with good effect.

In an interview NP #114 indicated they recalled being called early in the morning regarding resident #011, and instructed registered staff to obtain palliative orders from

the physician and they would come to assess resident #011. The NP indicated that they had assessed the resident and instructed staff to follow the physician orders, and went to see another resident. They recalled returning to the unit and RPN #109 asking if they could administer the identified PRN medication as the resident was in distress, and instructed the RPN to give the medication. NP #114 indicated they had seen the resident earlier, the registered staff had the orders from the physician and they should have given the medication as the resident was in distress upon their assessment. The NP indicated they believed RN #110 was caring for resident #011 and not RPN #109.

RN #110 no longer worked in the home and was not able to be reached for interview related to this inspection.

In an interview, the Director of Resident Services acknowledged that as resident #011 was in discomfort and showing indicators of respiratory distress upon assessment by RN #110, they should have been administered medications for comfort as ordered by the physician. The DRS acknowledged that as resident #011 was not administered the PRN medication for several hours until RPN #109 administered the medication, that resident #011 did not receive end-of-life care in a manner that met their needs. [s. 42.]

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 every resident receives end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.

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.