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
Oct 29, 2021	2021_891649_0017	022997-20, 024817-20, 011065-21	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), JOY IERACI (665)

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 26, 27, 30, 31, September 1, 2, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, October 1, 5, off-site September 3, 7, 8, October 8, and 12, 2021.

The following Critical Incident System (CIS) intakes were completed during this CIS inspection:
Log #022997-20, CIS #3020-000038-20 related to prevention of abuse and neglect,
Log #024817-20, CIS #3020-000049-20 related to Residents' Bill of Rights.

The following Compliance Order (CO) follow-up intake was completed during this CIS inspection:
Log #011065-21 related to prevention of abuse and neglect.

A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s. 5 and a WN related to s. 6. (9) 1, were identified in this CIS inspection which was conducted concurrently with Complaint inspection report #2021_891649_0018, dated October 29, 2021, and issued in that report.

During the course of the inspection, the inspector(s) spoke with the Director Resident Services (DRS), Infection Prevention and Control (IPAC) Lead & Clinical Educator, Maintenance Manager (MM), Interim-Executive Assistant, Registered Nurses (RNs), Behavioural Supports Ontario (BSO) Nurse, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance, Housekeeper Aide, Front Desk Security, and residents.

During the course of the inspection the inspector observed staff to resident interactions, reviewed residents' clinical records, the home's temperature records, staffing schedules and observed IPAC practices.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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 #004	2021_644535_0005	665

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from physical abuse.

Under O. Reg. 79/10, for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to section (2), the use of physical force by a resident that causes physical injury to another resident.

The home submitted a Critical Incident System (CIS) report related to an incident of resident to resident physical abuse. According to the CIS report a resident pushed another resident causing them to fall and sustained an injury.

Record review indicated there was a previous incident involving the first resident (who pushed the other resident) and another resident that had occurred less than a month prior to the above mentioned incident. As a result of the previous incident, the first resident was provided with a 1:1 PSW during specific shifts.

The first resident did not have a 1:1 PSW due to a staffing issue, when the above mentioned incident occurred with the resident who sustained an injury. The PSW who was assigned to the first resident was required to complete their regular assignment as well as monitor the resident. The PSW was feeding another resident when the first resident pushed another resident resulting in an injury.

This incident was witnessed by another staff who confirmed that the first resident pushed another resident resulting in them falling and subsequent injury. Therefore, resident to resident physical abuse had occurred.

Sources: resident’s health records, interviews with PSWs, and other staff. [s. 19. (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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home.

Staff interviews indicated that each maintenance staff was responsible to measure and document the temperature in the home once daily. This was done through the home's maintenance program called Workxhub which auto-generated a daily work order for each maintenance staff reminding them to measure and record the temperature. According to the maintenance staff the location where the temperature was to be measured was not indicated on the work order, that decision was left up to the maintenance staff. The home's current practice was not in-line with the legislation that required the measurement of the temperature in two resident bedrooms in different parts of the home.

Review of the home’s air temperature records for the period of 14 weeks, indicated that the air temperature was not measured and documented for approximately 60 random days in at least two resident bedrooms in different parts of the home.

The Maintenance staff told the inspector that they measured and documented the

temperature from the daily work order. They confirmed that the work order did not provide the location of where the temperature was to be measured, that decision was left up to them.

The Maintenance Manager (MM) acknowledged the above gaps and told the inspector that they were implementing a new process to have air temperatures measured and documented by housekeeping and nursing staff in two resident bedrooms in different parts of the home.

Sources: review of the home's temperature records for 14 weeks, interviews with Maintenance staff and MM. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

Staff interviews indicated that each maintenance staff was responsible to measure and document the temperature in the home once daily. This was done through the home's maintenance program called Workxhub which auto-generated a daily work order for each maintenance staff reminding them to measure and record the temperature. According to the maintenance staff the location where the temperature was to be measured was not indicated on the work order, that decision was left up to the maintenance staff. The home's current practice was not in-line with the legislation that required the measurement of the temperature in one resident common area on every floor of the home.

Record review indicated that the home has two wings: Fidani and Fusco. Fidani has five resident home areas and Fusco has four resident home areas.

Further review of the home's air temperature records for the period of 14 weeks, indicated that the air temperature was not measured and documented in one resident common area on every floor of the home as this was not the home's practice.

The Maintenance staff told the inspector that they measured and documented the temperature once daily from the work order. They confirmed that the work order did not provide the location of where the temperature was to be measured that decision was left up to them.

MM acknowledged the above gaps and told the inspector they were implementing a new

process to have air temperatures measured in one resident common area on every floor of the home.

Sources: review of the home's temperature records for 14 weeks, interviews with Maintenance staff and MM. [s. 21. (2) 2.]

3. The licensee has failed to ensure that the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Staff interviews indicated that each maintenance staff was responsible to measure and document the temperature in the home once daily. This was done through the home's maintenance program called Workxhub which auto-generated a daily work order for each maintenance staff reminding them to measure and record the temperature. According to the maintenance staff the location where the temperature was to be measured was not indicated on the work order, that decision was left up to the maintenance staff. The home's current practice was not in-line with the legislation that required the measurement of the air temperatures once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Review of the home's air temperature records for the period of 14 weeks, indicated that the temperature was not measured and documented on many days and at the following specified time intervals. Gaps noted are as follows:

-18 random days the temperature was not measured.
-20 random days the temperature was not measured in the morning.
-63 random days the temperature was not measured between 12 p.m. and 5 p.m.
-85 random days the temperature was not measured in the evening or night.

Maintenance staff told the inspector that they measured and documented the temperature from the daily work order. They confirmed that the work order did not provide the location or the frequency of which the temperature was to be measured and documented.

MM acknowledged the above gaps and told the inspector that they were implementing a new process to have air temperatures measured and documented by housekeeping and nursing staff at the above mentioned required frequency.

Sources: review of the home's air temperature records for 14 weeks, interviews with Maintenance staff and MM. [s. 21. (3)]

Issued on this 2nd day of November, 2021

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

Original report signed by the inspector.