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
Jun 22, 2021	2021_644535_0004	022831-19, 024166-19, 017152-20, 017501-20, 019607-20, 019953-20, 021009-20, 022905-20, 023768-20, 025742-20, 000436-21, 001885-21	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

VERON ASH (535)

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): February 23, 24, 25, 26, March 1 - 5, 8-12, 16-19, and off-site March 23-26, April 1,5, 6, 7, 2021.

The following intakes were completed during this inspection:

Log #022831-19 was related to compliance order #001 from inspection #2019_804600_0022 regarding s. 6 (7), with compliance due date September 24, 2020;
Log #024166-19 was related to compliance order #002 from inspection #2019_751649_0019 regarding s. 50 (2), with compliance due date September 24, 2020;
Log #017152-20, CIS#3020-000015-20; #017501-20, CIS#3020-000016-20; #019607-20, CIS#3020-000022-20; #021009-20, CIS#3020-000029-20; #022905-20, CIS#3020-000040-20; #023768-20, CIS#3020-000046-20; #025742-20, CIS#3020-000051-20 and #000436-21, CIS#3020-000001-21 were related to falls;
Log #019953-20 was related to abuse; and
Log #001885-21 was related to unexpected death.

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 19 (1) and s. 6 (10) b and a Voluntary Plan of Correction related to s. 30 (2) were identified in this inspection and has been issued in a concurrent inspection, #2021_644535_0005, dated June 22, 2021.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Services (DRS), Director of Nursing Unit (DNU), Infection Prevention and Control Lead (IPAC Lead), Physiotherapist (PT), Behavior Support Ontario registered staff (BSO RPN), registered staff (RN/RPN), personal support workers (PSWs) and substitute decision-makers (SDM).

During the course of the inspection, the inspector conducted observations related to screening at the entrance of the home, resident home areas, resident to resident and staff to resident interactions, reviewed clinical health records, staffing schedule, internal investigation records, follow up compliance plans, multiple audits, new protocols, supportive and educational resources and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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
O.Reg 79/10 s. 50. (2)	CO #002	2019_751649_0019	535
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_804600_0022	535

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee had failed to ensure that a resident was reassessed and the plan of care reviewed when care set out in the plan had not been effective, and different approaches considered in the revision of the plan of care.

The MLTC received a critical incident report on an identified date, regarding a fall with injury.

The resident's falls assessment indicated that they were at risk for falls. No new fall prevention strategies were implemented and they had a subsequent fall with injury.

The Physiotherapist and RPN both acknowledged that the resident was not reassessed when the plan had not been effective, and different approaches were not considered to prevent future falls. They stated that the falls prevention plan should have been reassessed and the resident provided with an identified intervention to alert the staff when the resident attempted to get up.

Sources: CIS report, resident’s assessment records, interviews with PT, RPN and others. [s. 6. (11) (b)]

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 was reassessed and the plan of care reviewed when care set out in the plan had not been effective, and different approach considered in the revision of the plan of care., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown or wounds, they received immediate treatment and interventions to promote healing and prevention infection.

The RPN identified that the resident's impaired skin integrity worsened and showed signs of an infection. The RPN completed a referral, however the wound care specialist was not able to enter the home as a result of the COVID-19 outbreak.

The RPN stated that they had informed the RN one week earlier that the resident's impaired skin integrity required assessment and treatment. The RN stated that they were not aware that the resident's impaired skin integrity had worsened, however they discussed the concern with the physician and received an order for treatment. Both staff acknowledged that the physician or Nurse Practitioner (NP) should have been made aware of the status of the worsening condition earlier to provide treatment and interventions to promote healing and prevention infection.

Sources : CIS report, resident's progress notes, EMAR/ETAR, interviews with RN, RPN and others. [s. 50. (2) (b) (ii)]

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 when residents who exhibit altered skin integrity, including skin breakdown or wounds, receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevention infection, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's responsive behavioral triggers were identified where possible.

During an identified period, registered staff documented that the resident displayed a new responsive behavior. Weeks later, the resident's written care plan was updated when an internal responsive behavior assessment was completed by the BSO RPN. Prior to that assessment, there were no responsive behavior assessment and triggers identified related to the resident's new displayed behavior. The BSO RPN also notified external behavioral outreach teams who attended the home, assessed the resident and continued to monitor and support their behavior.

Sources : CIS report, resident’s progress and consultation notes, interview with BSO RPN and others. [s. 53. (4) (a)]

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 residents responsive behavioral triggers were identified where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that wraps, strips or bandages were not used in the home to restrain a resident.

During an identified shift, the resident removed their protective dressing which the RPN replaced several times. A specific device was ordered by the physician, however the RPN was unable to locate that device in the home. They decided to use other materials instead of the device ordered. The materials restricted the resident's movements and prevented them from removing the protective dressing.

The RPN stated they had to use those materials since the resident was repeatedly removing the intervention put in place and they were concern for the resident's health and safety. They acknowledged that they used a form of restraint which was not approved by the facility and stated that they were trying to prevent further harm and injury to the resident.

Sources : CIS report, home's restraint policy, resident’s progress notes, interview with RPN and others. [s. 112.]

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 wraps, strips or bandages were not used in the home to restrain a resident, to be implemented voluntarily.

WN #5: 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. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's unexpected death which occurred outside normal business hours, was immediately reported to the Director.

The MLTC received a critical incident report on an identified date, related to a sudden or unexpected death.

The CIS indicated that they found the resident unresponsive, and the registered staff notified paramedics, physician, substitute decision-maker (SDM) and the Director of Nursing Unit (DNU) during the shift.

The DNU acknowledged that they were made aware of the incident during the shift; however, they did not contact the MLTC after hours reporting line to immediately report the incident.

Sources: CIS report, resident's progress notes, interview with DNU and others . [s. 107. (2)]

Issued on this 13th day of July, 2021

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

Original report signed by the inspector.