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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 25, 2022
Inspection Number 2022_1514_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Villa Colombo Homes for the Aged Inc.

Long-Term Care Home and City
Villa Colombo Home for the Aged; North York

Lead Inspector
Matthew Chiu (#565)

Additional Inspector(s)
Reji Sivamangalam (#739633)

Inspector Digital Signature
Matthew Chiu
Digitally signed by Matthew Chiu
Date: 2022.08.18 15:54:48 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 30, July 4-7, and 11, 2022, on-site; July 12-13, and 19, 2022, off-site.

Inspector Kwesi Douglas (736409) was present during the first day of this inspection.

The following intake(s) were inspected:
- #009241-22 (Complaint) and #010304-22 (Complaint) related to alleged improper care to residents.

The following **Inspection Protocols** were used during this inspection:
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102. (2) (b)

The licensee has failed to ensure that the requirement of supporting residents to perform hand hygiene prior to receiving meals, included in the infection prevention and control (IPAC) standard issued by the Director, was implemented by staff.

Rationale and Summary:

a. Two residents were observed walking into a dining room for lunch. No staff supported them with hand hygiene prior to being served their meal. These residents were capable to eat independently in the dining room.

Staff interviews indicated this was the responsibility of a resident's primary personal support worker (PSW) to assist their assigned resident with their hand hygiene in the dining room. There was no team member designated to oversee the resident's hand hygiene.

b. In another home area, staff did not assist resident #003 with hand hygiene. Staff acknowledged that they did not assist the resident with hand hygiene before the meal and verified that they should have.

Failure to support the residents with hand hygiene increased the risk of transmission of infection.

Sources: Observations; the home's policy titled "Hand Hygiene" No. IC-02-01-08 last reviewed on June 2021; interviews with the PSW and IPAC Lead. [#739633]

WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in two residents' plans of care was provided to the residents as specified in the plans.

Rationale and Summary:

a. A resident's plan of care specified that they required two-staff assistance for care.

In a shift, a PSW provided the care to the resident on their own without assistance from another staff member. Staff interviews and record review indicated that the PSW found the resident sustained an injury after their care. The resident was assessed and taken to the hospital for treatment.

Sources: Resident's care plan, progress notes; home's investigation records; interviews with the PSW, Nurse Manager (NM), and other staff. [#565]

Rationale and Summary:

b. Another resident had responsive behaviours. One of the interventions specified in their plan of care was not provided to the resident in the dining room.

The resident demonstrated a responsive behaviour in the dining room and did not eat their meal.

Failure to provide the care to the resident specified in the plan of care put them at risk of not meeting their nutritional needs.

Sources: Resident's care plan; observation; interviews with the NM and Staff. [#739633]

WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for one resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary:

a. The resident's nutritional plan of care specified a full size snack item should be provided for the resident. In a shift, the resident received only half of the snack item.

The Dietary Supervisor (DS) verified that the dietary order was not clear for the staff to prepare the item in the required full size.

Failure to set out clear directions for providing the snack increased the risk of the resident not meeting their nutritional requirements.

Sources: Resident's nutritional care plan; interviews with the PSW and DS. [#739633]

Rationale and Summary:

b. The resident was at risk of a health condition per the care plan. One of the interventions specified in their plan of care for preventing the condition was not provided to the resident due to responsive behaviours.

The NM verified that the resident's plan of care did not set out clear directions on what care should be provided to the resident for preventing the condition if the specified care cannot be given.

Failure to set out clear directions in the resident's plan of care increased the resident's risk of developing the heath condition.

Sources: Observation; resident's care plan; interviews with the Registered Practical Nurse (RPN) and NM. [#739633]

WRITTEN NOTIFICATION PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that one resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of resident's plan of care.

Rationale and Summary:

The resident had responsive behaviours during care. The SDM had informed the home that an intervention could be used to manage the resident's responsive behaviours.

The NM verified that the above-mentioned intervention was not implemented to manage the resident's behaviour during care. The home did not inform the SDM that it was not utilized as an intervention to assist in managing the resident's responsive behaviors during care.

The non-compliance increased the risk of harm to the resident and others as a result of responsive behaviors.

Sources: Resident's progress notes; interviews with the SDM, RPN, NM, and PSW. [#739633]

WRITTEN NOTIFICATION FOOT CARE AND NAIL CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 39 (1)

The licensee has failed to ensure that one resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and Summary:

The resident was dependent for care and were to receive footcare services, including cutting of toenails, on a monthly basis. The resident did not receive foot care services from the home for a four-month period. In a shift, the resident sustained an injury during care. Staff stated the resident's toenails were at a specified length and shape.

The non-compliance resulted in a moderate risk of impact to the resident's health and increased the risk of infection to the resident.

Sources: Resident's progress notes; home's investigation records; interviews with the PSW and NM. [#565]

WRITTEN NOTIFICATION TRANSFERRING AND POSITIONING TECHNIQUES

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe positioning techniques when assisting one resident.

Rationale and Summary:

The resident was dependent for care. Staff interviews stated that when transporting the resident with an equipment, a safe positioning technique should be used to assist the resident.

In a shift, a PSW transported the resident with the equipment without using the safe positioning technique. As a result, the resident sustained an injury.

Sources: Resident's care plan and progress notes; home's investigation records; interviews with the PSW, NM, and other staff. [#565]

WRITTEN NOTIFICATION MAINTENANCE SERVICES

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)

The licensee has failed to ensure that procedures were implemented by staff to ensure that an equipment in the home was kept in good repair.

Rationale and Summary:

The home's maintenance program had procedures for reporting and managing equipment that was broken. Direct care staff should report broken equipment to their registered staff or nurse manager. The registered staff or nurse manager would make a service request using their online system to notify maintenance staff for proper action. The broken equipment should have been removed from the unit to prevent it from being used.

In a shift, when a PSW used the equipment to assist a resident, it was broken. The PSW continued to use the equipment for the resident on that day, and the resident sustained an injury.

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Approximately two months later, during separate staff interviews and observations on three days, the same equipment was found broken and it was not removed from the unit. Staff did not report the broken equipment or remove it from the unit.

Sources: Observations; home's online service request records; interviews with the PSW, RPN, Maintenance Manager (MM), and the Director of Resident Services (DRS). [#565]