Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 25, 2024

Inspection Number: 2024-1514-0001

Inspection Type:
Critical Incident

Licensee: Villa Colombo Homes for the Aged Inc.

Long Term Care Home and City: Villa Colombo Homes for the Aged, Toronto

Lead Inspector	**Inspector Digital Signature**
Reji Sivamangalam (739633)	Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2024.05.06 09:04:25 -04'00'

Additional Inspector(s)
Ryan Randhawa (741073)

Amal Ahmed (000819) and Safi Mohamed (000826) were present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19 - 22 and 25 - 28, 2024

The following intake(s) were inspected:

- Intake: #00104941 [Critical Incident System (CIS) #3020-000130-23] related to a disease outbreak.
- Intake: #00105941 (CIS #3020-000005-24) related to allegations of improper care of a resident
- Intake: #00106715 (CIS #3020-000007-24) related to unknown cause of an injury to a resident.

- Intake: #00109732 (CIS #3020-000015-24) related to fall prevention and management.

The following intake (s) were completed:

- Intakes: #00103276 (CIS #3020-000125-23), #00104477 (CIS #3020-000129-23), #00105458 (CIS #3020-000002-24), #00105771 (CIS #3020-000003-24), #00110868 (CIS #3020-000020-24), and #00105139 (CIS #3020-000132-23) were related to fall prevention and management.
- Intakes: #00105786 (CIS #3020-000004-24), #00106828 (CIS #3020-000008-24) and #00111621 (CIS #3020-000021-24) were related to disease outbreaks.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the level of assistance for activities of daily living (ADL) was provided to the resident as specified in the plan.

Rationale and Summary:

The resident's care plan indicated that they required assistance for some ADL tasks.

A staff member indicated that they provided the resident with a different level of assistance with the ADL tasks, The resident's documentation confirmed that the staff member did not provide the required assistance for the ADL tasks on multiple days.

The Nurse Manager and the Director of Care (DOC) both indicated that the expectation was that the care being rendered should follow the plan of care.

The resident was at increased risk of injury when the required assistance for the ADL tasks was not provided to them as specified in the plan.

Sources: The resident's clinical records; interviews with the staff members.

[741073]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care for the resident was documented.

Rationale and Summary:

The resident exhibited behavioral changes and refused assistance with some tasks for ADL on a specified shift.

Staff members indicated that they did not complete the tasks for the resident on the shift.

The resident's documentation indicated that the staff member documented that they assisted the resident with the ADL tasks. The staff member acknowledged that the resident was not assisted with the ADLs on the shift. The staff member, Nurse Manager and the DOC indicated that the staff member should have documented that the resident had refused care for the ADLs.

Failure to ensure that the provision of the care set out in the plan of care for the resident was documented correctly provided minimal risk to the resident.

Sources: Resident's clinical records; interviews with the staff members.

[741073]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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.

The licensee has failed to ensure that a resident received a skin assessment for an area of altered skin integrity.

Rationale and Summary:

The resident had a fall and sustained an injury that resulted in altered skin integrity. They were taken to the hospital for further investigation and returned to the home with treatment for their injury.

A review of the resident's clinical records indicated that registered staff did not complete an assessment of altered skin integrity using the home's skin assessment tool.

Three staff members acknowledged that an assessment of the resident's altered skin integrity was not completed as required according to the home's skin and wound policy. The DOC confirmed that staff were expected to complete the assessment and acknowledged that it was not completed.

Failure to complete a skin assessment increased the resident's risk of improper management of the altered skin integrity.

Sources: Resident's clinical records, the home's Policy, and interviews with the staff members.

[739633]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The licensee has failed to ensure that an intervention was provided to a resident to manage their responsive behaviors.

Rationale and Summary:

The resident exhibited a particular responsive behaviour and an intervention was implemented as a strategy to manage this behaviour.

On an identified date the resident was found on the floor after a fall with an injury.

The staff members confirmed that the resident required the interventions to manage their responsive behaviour. They acknowledged that the intervention was not provided during the shift and at the time of the resident's fall.

The DOC confirmed that the resident should have received the intervention to manage their responsive behaviours.

Failure to provide the intervention to the resident increased their risk of falls and injuries associated with the responsive behaviour.

Sources: Resident's clinical records, interviews with staff members.

[739633]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms of an infection were recorded for residents.

Rationale and Summary:

An infectious disease outbreak was declared at the home following residents symptoms identified and a number of residents were included in the outbreak line list. A review of their clinical records revealed incomplete symptom recording across all shifts for these residents.

The DOC confirmed that staff were required to document residents' infection-related symptoms on all shifts.

Failure to record symptoms placed residents at risk of inconsistent disease monitoring and potential delays in responding to worsening conditions.

Sources: Residents' clinical records and interview with the DOC.

[739633]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (5) (b)
Dealing with complaints
s. 108 (5) Where a licensee is required to immediately forward a complaint under clause 26 (1) (c) of the Act, it shall forward it in a form and manner acceptable to the Director, and,
(b) outside normal business hours, using the Ministry's after hours emergency contact method.

The licensee has failed to immediately forward a complaint outside normal business hours, concerning the care of a resident, using the Ministry's after hours emergency contact method.

Rationale and Summary:

The home received a written complaint concerning the care of the resident related to their health conditions and medication use.

A critical incident report was submitted by the home to the Director. The home was instructed to amend the critical incident report and submit the mandatory report as per section 28 of the FLTCA, 2021 regarding the complaint. The Nurse Manager confirmed that the home did not use the Ministry's method for after hours emergency contact, the Service Ontario After-Hours Line, when submitting the complaint outside normal business hours.

Failure to report the complaint critical incident after normal business hours using the Ministry's method for after hours emergency contact method, provided minimal risk to the resident.

Sources: MLTC Reporting Requirements - reference sheet; interviews with the staff members.

[741073]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (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 (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The license has failed to immediately report an infectious outbreak to the Director.

Rationale and Summary:

Toronto Public Health (TPH) declared an infectious disease outbreak.

The Long-Term Care (LTC) Homes Afterhours was called the next day instead of the same day when the outbreak was declared.

The DOC acknowledged that the Director was not immediately informed about the outbreak as required.

Failure to immediately report the disease outbreak to the Director increased the risk of delayed monitoring of the home's outbreak situation.

Sources: Outbreak management checklist, Infoline After Hours Report, interviews with staff members.

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WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:

A resident was ordered a drug with a specific dosage regime.

A review of the resident's medication order entered into the home's electronic health care record indicated that the pharmacy entered the order incorrectly in the resident's electronic medication administration record (eMAR), which a registered staff member confirmed.

A review of the medication administration record (MAR) and confirmation by the registered staff member and Nurse Manager both indicated that the resident had the medication administered incorrectly until the order was updated on the eMAR to reflect the prescribed order. During this time period, the resident received the medication for additional time than required.

The resident was at increased risk for undesired clinical effects when the medication was administered incorrectly and not as specified by the prescriber.

Sources: Resident's clinical records; Interviews staff members.

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COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Re-train the identified staff on the home's hand hygiene policy specifically on the four moments of hand hygiene.
2) Conduct random audits of the identified staff member's hand hygiene practices during meal service, for a minimum of two shifts weekly for a period of three weeks following the service of this order.
3) Maintain a record of the audits conducted, to include, but not limited to: audit dates, name of person(s) completing the audits, audit findings and any corrective action taken in response to the audit findings.
4) Re-train the identified staff on the proper selection of Personal Protective Equipment (PPE) including doffing of PPE after use for residents on additional precautions.
5) Re-train the identified staff on the requirements of doffing of PPE after use for residents on additional precautions.
6) Maintain a record of the education, including the content, date, signatures of staff members who attended and the staff member who provided the education.

Grounds

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b & f) stated that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to the four moments of hand hygiene. Additional Precautions shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary:

1. During an observation, a staff member did not perform hand hygiene after handling soiled dishes and before obtaining food from the serving area. They then proceeded to assist two residents and failed to perform hand hygiene before providing assistance. After they proceeded to assist two residents in two different rooms, they failed to follow the four moments of hand hygiene. No hand hygiene was performed in between providing assistance to either of the two residents.

The staff member, Infection Prevention and Control (IPAC) Lead and the DOC acknowledged that the staff member was expected to perform hand hygiene after handling soiled dishes, before handling food, and between assisting residents. Failure to perform hand hygiene increased the risk of disease transmission among residents.

Sources: Observations, interviews with the staff members and IPAC standard for Long-Term Care Homes, April 2022 (Revised September 2023).

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2. A staff member was observed entering a resident's room that was on droplet and contact precautions. There was signage on the door for the required PPE: N95 mask, eye protection, gown and gloves. The staff member donned a surgical mask, face shield, gown and gloves and entered the room. Upon completing the required tasks, they doffed the gown and gloves but continued wearing the surgical mask and face shield after exiting the resident's room.

The staff member acknowledged that they should have worn an N95 mask before entering the room and remove the surgical mask and face shield upon exiting.

The registered staff member verified that the resident's room was on droplet and

contact precautions, and staff members should don an N95 mask upon entering the room.

3. On the same day a registered staff member entered a resident's room on droplet and contact precautions and donned an N95 mask, face shield, gown, and gloves. Upon exiting the room, they doffed the gown and gloves but continued to wear the N95 mask and face shield after exiting the resident's room and while attending to another resident.

The staff member acknowledged not removing the N95 mask and face shield upon exiting the resident's room.

The IPAC Lead and the DOC both verified that the staff members did not follow the required precautions for appropriate PPE use.

Failure to follow the posted additional precautions increased the risk of infection transmission among residents and staff.

Sources: Observations, interviews with staff members, residents' clinical records, home's "Personal Protective Equipment" policy and IPAC standard for Long-Term Care Homes, April 2022 (Revised September 2023).

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This order must be complied with by June 10, 2024

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.