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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Mar 8, 2022	2022_631210_0002	013762-21, 013795-21, 013961-21, 014662-21, 014805-21, 017975-21, 019747-21	Complaint

Licensee/Titulaire de permis

Friuli Long Term Care
7065 Islington Avenue Woodbridge ON L4L 1V9

Long-Term Care Home/Foyer de soins de longue durée

Villa Leonardo Gambin
40 Friuli Court Woodbridge ON L4L 9T3

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

SLAVICA VUCKO (210)

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): January 26, 27, February 1, 2, 3, 7, 8, 9, 10, 11, 14, and 15, 2022.

During the course of the inspection the following Complaints were inspected:
-intake #019747-21, #014662-21, #013961-21, #013762-21 related to alleged abuse,
-intake #017975-21 associated with a Critical Incident System (CIS) report, intake #017709-21, related to fracture of unknown cause, alleged abuse, nutrition and hydration programs,
-intake #013795-21, #014805-21 related to maintenance service, personal care services, nutrition and hydration, dealing with complaints.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support workers (PSWs), Behavioral Support Ontario (BSO) Lead, Registered Dietician (RD), Physiotherapist (PT), Director of Environmental Services (DES), Infection Prevention and Control (IPAC) Lead, residents and family members.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed the home's internal investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other.

A Critical Incident System (CIS) report and a complaint was submitted to the Ministry of Health and Long term Care (MLTC) that on a specified date resident #001 sustained an injury of unknown cause.

Resident #001 was able to weight bear. On a specified date resident #001 was transferred with two-person assistance according to the resident's care plan. In the morning, two PSWs assisted the resident with continence care. One PSW noted a skin impairment on the resident's body and did not report it to the Registered Nurse. A third PSW noted the skin impairment, and that the resident experienced discomfort. The resident was sent to hospital for further assessment on the same day and was diagnosed with an injury of which later they recovered from.

Staff did not communicate the altered skin integrity on resident #001's body immediately upon discovering it.

There was no harm to the resident, because of this non-compliance.

Sources: CIS report, home's investigation record, review of resident #001's clinical record, interviews with staff. [s. 6. (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 that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #001 so that their assessments are integrated, consistent with and complement each other, 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been assessed by a registered dietitian who is a member of the staff of the home.
When a Dietitian referral was not completed, there was a risk that the resident would not receive the appropriate RD interventions to facilitate healing of the altered skin integrity.

A complaint was submitted to the MLTC that resident #003 had altered skin integrity for

an identified time period that was not treated appropriately.

Resident #003 was treated for altered skin integrity for an identified time period.

Registered Dietician (RD) assessed the nutritional status of resident #003 during the same time period, but was not aware that the resident had skin alterations, as they did not receive a referral.

There was no harm to the resident, because of this non-compliance.

Sources: review of a complaint report, resident #003's clinical record, interviews with staff. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Resident #003 had altered skin integrity and was treated for an identified time period.

According to home's policy Skin and Wound Care Management Protocol, VII-G-10.90, dated November 2021, the nurse will identify any skin integrity alterations, including skin breakdown, pressure injuries, skin tears or wound, will follow up with assessments such as Skin and Wound Assessment, and complete an electronic Head to Toe Assessment weekly until healed. If a wound is worsening or is not responding to treatment, initiate an electronic referral to the Skin Care Resource Nurse for assessment.

Resident #003's altered skin integrity was not assessed weekly from inceptions until healed.

There was no harm to the resident, because of this non-compliance.

Sources: review of resident #003's family complaint, resident #003's clinical record, interviews with staff. [s. 50. (2) (b) (iv)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine, preventive and remedial maintenance.

A complaint was submitted to the MLTC about inappropriate care provided to resident #002 during activities of daily living (ADL).

Resident #002 required a specific type of lift for transfer. During a specified time period, on more than one occasion while the resident was being transferred, the lift would stop working. Staff managed to transfer the resident safely.The resident was suspended in the air a little longer than required and was not injured during the transfers.

During a review of the lift supplier audit report, the life expectancy of a certain number of batteries had expired and needed to be replaced, because they did not hold sufficient charge to be used safely. Since then all defective lift batteries were replaced.

The home was unable to demonstrate an organized program of maintenance services, such as a schedule and procedures in place for routine, preventive and remedial maintenance of the lifts being used to transfer residents safely in the home.

Sources: review of resident #002’s family complaint, home’s lift batteries audit form, observations, interviews with staff. [s. 90. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #003 in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the MLTC about resident #003 not receiving prescribed medications on time on a specified date.

The resident had multiple health issues which were treated with specific medications. They were scheduled to be administered once or twice a day.

On a specified date, a registered staff found that identified medications were not administered as scheduled. They consulted the Physician, informed the Substitute Decision Maker (SDM) and administered the medications later on the same day. The resident was monitored and did not present with adverse effects related to the late medication administration.

Resident #003 did not receive their medications on time as prescribed by the Physician.

Sources: review of resident #003's clinical record, interview with registered staff and other staff. [s. 131. (2)]

Issued on this 10th day of March, 2022

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

Original report signed by the inspector.