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
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Original Public Report

Report Issue Date: February 21, 2023	
Inspection Number: 2023-1431-0003	
Inspection Type: Critical Incident System	
Licensee: Friuli Long Term Care	
Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge	
Lead Inspector Christine Francis (740880)	**Inspector Digital Signature** Christine Francis Digitally signed by Christine Francis Date: 2023.02.22 15:08:14 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 6-10, 13, 2023, with February 6-10, 2023 conducted on-site and February 13, 2023 conducted off-site.

The following intake(s) were inspected in this Critical Incident Systems (CIS) inspection:

- Intake: #00003658/CI: #2947-000002-22 - related to falls prevention and management
- Intake: #00014121/CI: #2947-000033-22 - related to potential improper transfer of resident by staff

The following intake(s) were completed in the Critical Incident Systems (CIS) inspection:

- Intake: #00001501/CI: #2947-000025-22 - related to falls prevention and management
- Intake: #00002334/CI: #2947-000023-22 - related to falls prevention and management
- Intake: #00005936/CI: #2947-000003-22 - related to falls prevention and management
- Intake: #00011553/CI: #2947-000030-22 - related to falls prevention and management
- Intake: #00013714/CI: #2947-000032-22 - related to falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that physical distancing requirements as required by a Minister's Directive and set out in the COVID-19 guidance document for long-term care homes in Ontario were followed.

Rationale and Summary
On February 6, 2023, the activity room on a resident home area had Infection Prevention and Control (IPAC) signage indicating capacity requirements for 12 persons, along with following physical distancing at all times. Inspector observed a total of 16 individuals in the activity room.

Recreation Assistant #100 acknowledged that the capacity requirements as indicated by the signage were not followed. IPAC Lead #104 indicated that signage posted on the activity rooms are expected to be followed, and there was a risk of infection transmission when the capacity requirements were not followed.

There was a risk of infection transmission when the home did not follow physical distancing and IPAC capacity requirements.

Sources: Observation on February 6, 2023, interview with Recreation Assistant #100 and IPAC Lead #104, and COVID-19 guidance document for long-term care homes in Ontario (last updated October 14, 2022).

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WRITTEN NOTIFICATION: Reporting Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed about an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary
The home went into an outbreak as declared by the Public Health Unit (PHU) on January 16, 2023. Director of Care (DOC) #105 acknowledged that the outbreak was declared on January 16, 2023, and was reported to the Ministry of Long-Term Care on January 17, 2023.

The Critical Incident Report indicated the outbreak was declared on January 16, 2023, however the report was first submitted to the Ministry of Long-Term Care on January 17, 2023.

There was low risk to the residents as the home had initiated outbreak measures as directed by the PHU.

Sources: Critical Incident Report #2947-000001-23, and interview with DOC #105.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 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 the plan of care was provided to the resident as specified in the plan.

Rationale and Summary
The resident's care plan indicated that they were at high risk for falls, and an identified risk was noted when they were in a particular position due to a particular responsive behaviour that would be exhibited. Their falls prevention interventions included specific interventions for the resident, to prevent further risk of falls with the resident when they exhibited their responsive behaviour.

On a specified date, the resident was observed without their falls intervention after care was rendered to the resident.

Registered Practical Nurse (RPN) #107 and Director of Care (DOC) #105 indicated that the falls intervention should be applied at all times when they are noted to be in a particular position. RPN #107

acknowledged that the resident's fall prevention intervention was not provided and that their care plan was not followed, which could result in another fall.

Due to staff failing to ensure that the resident's care is provided as set out in their plan of care, there was a risk of the resident having a fall with injury.

Sources: Observation on a specified date, the resident's care plan, and interviews with DOC #105, and RPN #107.

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WRITTEN NOTIFICATION: Plan of Care

NC #004 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 there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
On two separate identified dates, Inspector observed a specified falls intervention device attached to a resident's assistive device, however it was not attached to the resident.

The resident's written plan of care indicated their falls prevention interventions, however it did not indicate the specified falls intervention device to be used.

Personal Support Worker (PSW) #108 indicated that the resident had a specified falls intervention device that is to be attached, as the resident may exhibit a particular responsive behaviour when they are in a particular position and their falls prevention interventions are removed during care.

Registered Practical Nurse (RPN) #107 also indicated that the resident has a specified falls intervention device in case they exhibit a particular responsive behaviour when they are in a particular position, and that it should be attached to the resident; however it was not noted in the resident's care plan.

RPN #109 indicated that the resident did not have a specified falls intervention device included as part of their falls prevention interventions, and it was not applicable for the resident at this time.

Director of Care (DOC) #105 acknowledged that there were no clear directions to the staff and others who provided direct care to the resident.

When the resident's plan of care did not provide clear directions to the staff and others who provided direct care to the resident, there was a risk of the resident being provided with incorrect interventions for falls prevention.

Sources: Observations on specified dates, the resident's written plan of care, and interviews with PSW #108, RPN #107, and DOC #105.

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 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 transferring and positioning devices or techniques when assisting residents.

Rationale and Summary
During the course of the inspection related to a critical incident with injury, the Inspector was informed that the resident had a subsequent fall on a specified date.

The resident had a change in their transfer status after sustaining the initial fall.

Director of Care (DOC) #105 indicated that the resident had a subsequent fall during the provision of care, and the resident was transferred using the previous technique and not the one that was revised for the resident. Personal Support Worker (PSW) #115 acknowledged that they had performed a transfer using their previous transfer status, despite being made aware that the resident's plan of care had changed.

Due to the licensee failing to ensure that the resident was safely transferred, there was a risk of another fall with injury occurring.

Sources: The resident’s care plan, interviews with DOC #105 and PSW #115, and the home’s disciplinary form dated November 30, 2022.

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