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: February 22, 2024
Inspection Number: 2024-1431-0001
Inspection Type: Complaint Critical Incident
Licensee: Friuli Long Term Care
Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge

Lead Inspector	**Inspector Digital Signature**
Ryan Randhawa (741073)	Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2024.03.05 13:47:34 -05'00'

Additional Inspector(s)
Matthew Chiu (565)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 1-2, 5-9, 2024

The following intake(s) were inspected in this Critical Incident (CI) inspection:
•Intake: #00099937 - [CI: 2947-000029-23] and Intake: #00103835 - [CI: 2947-000039-23] - were related to outbreaks
•Intake: #00103765 - [CI: 2947-000036-23] - was related improper care
•Intake: #00103943 - [CI: 2947-000038-23] - was related to fall with injury
•Intake: #00107256 - [CI: 2947-000004-24] - was related to restraints

The following intake(s) were inspected in this complaint inspection:
•Intake: #00106236 was related to improper care

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The following intake(s) were completed in this CI inspection:
•Intake: #00098726 - [CI: 2947-000027-23], Intake: #00100305 - [CI: 2947-000030-23], and Intake: #00101352 - [CI: 2947-000032-23] were related to fall with injury.

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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 care was provided to a resident as specified in the resident's plan of care.

Rationale and Summary

Record review and staff interviews revealed that a resident had an illness. A Nurse Practitioner (NP) assessed them the next day, and the subsequent written plan of care for the resident included different interventions and instructions if symptoms worsen.

Further record review and staff interviews indicated that on the following day, the resident's symptoms worsened. Both NP and the Director of Care (DOC) stated that when the resident's condition deteriorated, staff should have implemented the instructions, but they did not. The resident's symptoms continued to worsen and the instructions were implemented two days later.

The non-compliance caused a risk of delayed medical intervention, worsening of symptoms, and increased severity of illness for the resident.

Sources: Resident's progress notes; interviews with Registered Practical Nurse (RPN), NP, and the DOC. [565]

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 a resident was documented.

Rationale and Summary

A resident's Documentation Survey Report indicated that on a day in December 2023, a Personal Support Worker (PSW) did not document all activities of daily living (ADL) for a specific resident.

The PSW indicated that they provided the resident with assistance with some of the ADLs and for other ADLs the resident was in the hospital, however the care needs were not documented. The PSW, Associate Director of Care (ADOC), and the DOC indicated that the PSW should have documented the ADLs they provided assistance with and that the resident was away from the home for the other ADLs.

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

Sources: Review of the resident's clinical records; interviews with PSW, ADOC, and DOC. [741073]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements

that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director upon receipt of the complaint.

Rationale and Summary

A written complaint was submitted to the DOC in relation to the care of a resident. The written complaint was submitted by the home to the Director on a day in December 2023.

The DOC acknowledged that the written complaint should have been submitted immediately to the Director, the day the written complaint was received.

Failure to forward the written complaint concerning the care of the resident to the Director provided minimal risk to the resident.

Sources: Resident's clinical records; Critical Incident (CI) Reports; written complaint; interviews with the DOC and other staff. [741073]

WRITTEN NOTIFICATION: Directives by Minister

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Minister's Directive, COVID-19 response measures for long-term care homes

directed homes to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. The guidance document stated long-term care homes must complete IPAC audits at least quarterly, in alignment with the requirement under the IPAC standard. When a long-term care home is in outbreak, the IPAC audits must be completed weekly. At minimum, the audits must include Public Health Ontario's "COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes".

The licensee has failed to carry out the infection prevention and control (IPAC) audits directive that applied to the long-term care home.

Rationale and Summary:

Beginning on December 9, 2023, the home experienced COVID-19 outbreak involving multiples floors. This outbreak continued into February 2024 concurrently with a respiratory outbreak. During this period of COVID-19 outbreak, IPAC audits were not conducted using the mentioned tool between December 11 and 21, 2023; January 3 and 11, 2024; and January 16 and 25, 2024.

The non-compliance caused the risk of undetected gaps in the home's infection prevention and control measures, potentially leading to prolonged outbreaks.

Sources: Home's IPAC self-assessment audit records, Minister's Directive: COVID-19 response measures for long-term care homes; interviews with the IPAC Lead and DOC. [565]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 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 when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

Rationale and Summary

The home's policy "Skin & Wound Care Management Protocol" directed registered staff to complete the electronic Skin & Wound Assessment using the Point Click Care (PCC) Skin & Wound Application.

The home received a complaint from family regarding altered skin integrity of a resident. The altered skin integrity was first noted by PSW and was documented in the progress notes.

A Registered Practical Nurse (RPN) and the DOC acknowledged that a skin and wound assessment was not completed for the altered skin integrity and that it should have been.

Failure to complete a skin and wound assessment for the resident who exhibited

alerted skin integrity put the resident at risk of not receiving the appropriate interventions in a timely manner.

Sources: Critical Incident Report, resident's clinical records; home's policy "Skin & Wound Care Management Protocol, VII-G-10.90" 14045430 ,revised 08/2023; interviews with RPN, DOC and other staff. [741073]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Rationale and Summary

The home's policy "Skin & Wound Care Management Protocol" directed registered staff to complete weekly electronic Skin & Wound Assessment using the PCC Application and the mobile device until skin alteration is closed/resolved.

The home received a complaint regarding altered skin integrity for a resident. The

altered skin integrity was first noted by a PSW and was documented in the progress notes.

The RPN and the DOC acknowledged that weekly skin and wound assessments were not completed for the altered skin integrity and should have been from when it was first noted until it was resolved.

Failure to complete weekly skin and wound assessments for the resident who exhibited alerted skin integrity put the resident at risk of the staff not knowing the progression of the altered skin integrity and potentially compromising the treatment plan.

Sources: Critical Incident Report, resident's clinical records; home's policy "Skin & Wound Care Management Protocol, VII-G-10.90" 14045430 ,revised 08/2023; interviews with RPN, DOC and other staff. [741073]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 infectious disease were recorded for a resident.

Rationale and Summary

A resident had an illness and exhibited symptoms. Interviews with the IPAC lead and DOC indicated that staff were required to monitor the resident's symptoms of infection during every shift and document them. However, on two night shifts, there was no recorded documentation of the resident's symptoms.

The failure to record symptoms of infection every shift caused a risk of ineffective care planning and potential of delayed interventions for the resident.

Sources: Resident's Daily Resident Status Assessment tools, progress notes, and vital records; interviews with RPN, the IPAC lead and DOC. [565]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (12) 2.
Infection prevention and control program
s. 102 (12) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza and COVID-19 at the appropriate time each year.

The licensee has failed to ensure that the immunization measures were in place to offer residents immunization against COVID-19 at the appropriate time of 2023, adhering to the Ministry of Long-Term Care recommended COVID-19 immunization schedules for residents.

Rationale and Summary

The Ministry of Long-Term Care sent a memorandum to long-term care (LTC) licensees dated June 23, 2023, subject: COVID-19 Response Measures Update, and stated that LTC home residents were recommended to receive a bivalent booster this Spring, provided six months have passed since their last vaccine dose or confirmed COVID-19 infection.

When a resident became eligible for COVID-19 immunization in April 2023, after six months had passed since their last vaccine dose, they were not offered COVID-19 immunization in the home until the end of November 2024. The home had not offered COVID-19 immunization to its residents until approximately the fall and winter of 2023.

Subsequently, due to the resident's health conditions and the presence of infectious disease outbreaks within the home, the vaccine was not administered to the resident.

The non-compliance increased the risk of health related complications as a result of the infection for the resident and contributed to the risk of spreading the virus within the home.

Sources: Resident's immunization records and progress notes, MLTC COVID-19 Response Measures Update dated June 23, 2023; interviews with the coroner, IPAC lead and DOC. [565]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 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 licensee has failed to ensure that the Director was immediately informed of an outbreak of disease of public health significance.

Rationale and Summary:

Review of the Critical Incident System report, home's outbreak communication records, and staff interviews revealed that the home experienced outbreaks of a disease on multiple floors from October to November 2023. The outbreak originated on a day in October 2023, as declared by the public health unit. However, it was not reported to the Director until the next day.

Sources: Critical Incident System report; home's outbreaks communication records; interviews with the IPAC lead and DOC. [565]

WRITTEN NOTIFICATION: Prohibited devices that limit movement

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 121 7.

Prohibited devices that limit movement
s. 121. For the purposes of section 38 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

The licensee has failed to ensure that for the purposes of section 38 of the Act, sheets were not used in the home other than for a therapeutic purpose.

Rationale and Summary

A resident was found by a RPN in their bed with their body wrapped in a top sheet. The sheet restricted the movement of the resident's arms and legs. There was no physical harm to the resident.

Two PSWs indicated that they wrapped the resident in the sheet. The RPN and the DOC indicated that the sheet was not used for a therapeutic purpose when it was wrapped around the resident and tied at the back. The DOC indicated that the sheets were to be used for blankets and that sheets were not appropriate to use as a restraint.

There was increased risk to the resident for altered skin, strangulation and injury when the home used a prohibited device, that is the sheet, that limited movement and restrained the resident for other than for a therapeutic purpose.

Sources: Resident's clinical records; Critical Incident Report; the home's investigation notes; interviews with PSWs, RPN, and the DOC. [741073]