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

Public Report

Report Issue Date: January 14, 2025

Inspection Number: 2024-1431-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Friuli Long Term Care

Long Term Care Home and City: Villa Leonardo Gambin, Woodbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-6, 9-11, 13, 16-17, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00130664/ CI #2947-000043-24 was related to fall prevention and management.
- Intake: #00129268/ CI #2947-000041-24 was related to resident injury.
- Intake: #00133005/ CI #2947-000047-24 was related abuse and neglect, medication management and care related concerns.
- Intakes: #00126746/ CI #2947-000036-24 and #00131507/ CI #2947-000044-24 were related to disease outbreak.

The following CI intakes were completed during this inspection:

- Intakes: #00123501/ CI #2947-000032-24, #00124890/ CI #2947-000035-24, #00127611/ CI #2947-000037-24, #00129254/ CI #2947-000039-24, #00129262/ CI #2947-000040-24 were related to fall prevention and management.

The following complaint intakes were inspected:

- Intakes: #00129374 and #00130410 were related to neglect, medication management and care related concerns.

- Intake: #00129581 was related to medication management.
- Intake: #00130556 was related to abuse and neglect and care related concerns.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (4) (b)
Plan of care
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,
(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.

The licensee failed to ensure that the staff members collaborated with each other in carrying out the physician order for a supporting device for a resident for injury management.

Rationale and Summary:

A resident was diagnosed with an injury. The Physician ordered a support device for the injury management. The Associate Director of Care (ADOC) informed the Physiotherapist (PT) to order the device. Restorative Aid (RA) placed the order with the vendor as directed by the PT. The home received the support device; however, it was not provided to nursing staff for application until two months later.

The resident was at risk of improper injury management, when the staff members failed to ensure timely implementation of the physician's order.

Sources: Resident's heath records, observations, interviews staff.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 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 an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a skin assessment using a clinically appropriate assessment instrument was completed when a resident exhibited altered skin integrity.

Rationale and Summary
A resident's clinical records, indicated altered skin integrity on specific dates. However, the required skin assessments were not completed.

The ADOC confirmed that staff were required to conduct a skin assessment when the resident showed signs of altered skin integrity.

The failure to assess the altered skin integrity increased the risk that appropriate assessment and treatment would not be provided to the resident.

Sources: Skin & Wound Care Management Protocol, Resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee failed to ensure that a resident had an assessment completed using a clinically appropriate assessment instrument, as required when there was a change in the resident's bowel function.

Rationale and Summary
A resident had a change in their bowel function. However, according to the clinical

records, the required continence assessment was not completed. The RN acknowledged that the assessment was not completed.

Failure to complete the continence assessment posed a risk that the resident's care plan would not be effectively implemented to address their specific needs.

Sources: Bowel Management Program Policy, Resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed, no later than one business day, after a resident's fall, which resulted in a significant injury requiring hospitalization.

Rationale and Summary:
A resident had a fall, resulting in an injury that required the resident to be sent to the hospital. Record review and interview with the Director of Care (DOC) confirmed that the incident was not reported to the Director until several days later via the Critical Incident System (CIS).

Sources: Resident's progress notes, CIS report, interview with the DOC.

COMPLIANCE ORDER CO #001 Plan of care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Conduct a multidisciplinary falls prevention plan of care review for a specified resident to ensure it is based on an assessment of the resident's fall prevention needs and preferences.
2. Maintain a record of the review, including the staff involved, the date of the review, the assessment on which the review was based, and any actions taken to address the review findings.
3. Upon completing the above-mentioned review, conduct weekly audits over a three-week period to ensure that the care set out in a resident's falls prevention plan is being provided as specified.
4. Maintain a record of the audits, including the auditor, dates and times of the audits, the results, and any actions taken to address the audit findings.
5. Conduct random audits on all three shifts for two weeks to ensure that assistance is provided for a specified resident's activities of daily living as specified in the plan of care.
6. Maintain a record of the audits, including the auditor, dates and times of the audits, the results, and any actions taken to address the audit findings.

Grounds

The licensee failed to ensure that a fall prevention intervention specified in a resident's plan of care was applied, and that certain level of assistance for activities of daily living was provided to another resident as outlined in their plan of care.

Rationale and Summary:
1) A resident had both physical and cognitive impairments and was at risk for falls. Their falls prevention plan of care required a device to be applied in their mobility aid.
a. The resident was found on the floor at a certain time and sustained an injury. Staff interviews and record reviews revealed that, prior to the fall, the resident was using their mobility aid without the required device applied.
b. On two separate occasions, the resident was observed using their mobility aid without the device applied. Staff interviews confirmed that the device was not applied as required in the resident's plan of care.

The DOC acknowledged that the device was not applied during the above-mentioned incidents as required. The noncompliance posed a risk that the resident would not receive timely assistance to minimize the risk of falls.

Sources: Resident's clinical records, home's investigation records, observations; interviews with staff.

Rationale and Summary:
2) A resident's written plan of care specified that a specific level of assistance was required for certain aspects of resident care. Staff members acknowledged that they provided the care by themselves on multiple occasions, both the morning and evening, without the level of assistance as outlined in the plan of care.

The ADOC confirmed that staff members were required to follow the resident's plan of care, ensuring the necessary level of care was provided.

Failure to provide the required assistance increased the risk of injury and compromised the quality of care delivered to the resident.

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

This order must be complied with by February 24, 2025

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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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.