Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 29, 2015 Dec 4, 2014	2014_382596_0011	T-108-14	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC.
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

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

VILLA COLOMBO SENIORS CENTRE
10443 HIGHWAY 27, KLEINBURG VAUGHAN ON L0J 1C0

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

THERESA BERDOE-YOUNG (596), JULIENNE NGONLOGA (502), TILDA HUI (512)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 5, 6, 7, 10, 12, 13, 14, 17 and 18, 2014.

The inspection was conducted concurrently with critical incident (T-759-13), and findings from this inspection are contained in this report.

During the course of the inspection, the inspector(s) spoke with administrator, administrative director of care (DOC-A), director of clinical services (DOC-C), programs manager (PM),family members, residents, personal support workers (PSW), registered dietitian (RD), registered nurses (RN), maintenance, Social Worker (SW), Office Manager (OM), registered practical nurses (RPN), MDS-RAI Coordinator, Food Services Coordinator (FSC), CQI/Infection Control Coordinator (IFC), Physiotherapist, MDS RAI coordinator, housekeeping staff, dietary aides, volunteers, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

11 WN(s)
4 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	Legendé 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 O.Reg 79/10, s. 17. Communication and response system Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that

the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily accessed by residents at all times.

On November 5, 2014, at 12:30 p.m. on the first floor in resident #31's room, the inspector observed the call bell cord in the washroom wrapped around the base of the handrails close to the wall at the back of the toilet. The resident would not be able to reach back and activate the call bell if he/she required assistance.

Interview with an identified PSW confirmed that resident #31 would not be able to reach the call bell to activate it when the cord was wrapped around the base of the handrails. [s. 17. (1) (a)] (512)

2. The licensee has failed to ensure that the resident-staff communication and response system is on at all times.

On November 6, 2014, at 11:30 a.m. the inspector observed resident #31 resting in bed with the call bell beside him/her. Upon examination, the button of the call bell was noted to be stuck, and not able to be pressed down to activate the call bell.
The inspector brought this to the attention of an identified staff who confirmed that the call bell was not functional. The non-functional call bell was repaired later that day. [s. 17. (1) (b)] (512)

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 the resident-staff communication and response system can be easily accessed by residents at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have receive retraining annually relating to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections.

Review of staff training records and interview with administrator confirmed that 25 percent of staff did not receive training in 2013 on The Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections. [s. 76. (4)] (596)

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 all staff have receive retraining annually relating to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device
Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident

under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

Record review indicated that resident #31 has an identified physical condition. When the resident is symptomatic, he/she is to be put back in bed with both padded side rails up. Resident is at high risk for falls related to the identified symptom. The resident had tried to get up from the bed due to confusion, when he/she was settled.

Interview with identified staff confirmed that the side rails are being used as a restraint to prevent resident #31 from getting out of bed.

Record review and interview with an identified registered staff confirmed that the use of bed rails as a restraint had not been ordered by a physician. [s. 110. (2) 1.] (512)

2. The licensee has failed to ensure that the documentation includes consent for the use of the physical device to restrain.

Record review indicated that resident #31 has an identified physical condition. When the resident is specific symptoms, the resident is to be put back in bed with both padded side rails up. Resident is at high risk for falls related to the symptoms. Resident #31 had tried to get up from the bed when he/she was settled.

Interview with an identified staff confirmed that the side rails are being used as restraint to prevent resident #31 from getting out of bed. Record review and interview with an identified registered staff confirmed that there is no evidence of consent from the substitute decision maker for the restraint. [s. 110. (7) 4.] (512)

3. The licensee has failed to ensure that the documentation includes all assessment, reassessment and monitoring, including the resident's response.

Record review indicated that when resident #31 is having specific symptoms, he/she is to be put back in bed with both padded side rails up. The resident had tried to get up from the bed when she was settled.

Interview with identified staff confirmed that the side rails are being used as a restraint to prevent him/her from getting out of bed. The resident was to be closely monitored whenever he/she is in bed.

Record review and interview with the staff confirmed that PSWs are frequently monitoring resident #31 whenever he/she is in bed. However, there was no documentation available related to on-going monitoring of the resident while in bed. [s. 110. (7) 6.] (512)

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:
1. staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class,
2.the documentation includes consent for the use of the physical device to restraint, and
3. the documentation includes all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

4. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants:

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management.

Record review of falls prevention and management training and interview with Administrative DOC revealed that 25 per cent of staff were not trained in 2013. [s. 221. (1) 1.] (596)

2. The licensee has failed to ensure that all direct staff are provided training in skin and wound care.

Record review of staff skin and wound care training records and interview with Administrative DOC confirm that 25 per cent of staff did not receive training in 2013. [s. 221. (1) 2.] (596)

3. The licensee has failed to ensure that training related to continence care and bowel management is provided to all staff who provide direct care to residents on either an annual basis or based on the staff's assessed training needs.

Record review of staff continence and bowel care training records and interview with the administrator confirmed that 25 per cent of staff who provide direct care to residents did not received training in 2013. [s. 221. (1) 3.] (502)

4. The licensee has failed to ensure that training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

Record review of staff restraint training records and interview with the administrator confirmed that 25 per cent of the home's staff who apply physical devices or who monitor them, did not receive training in 2013. [s. 221. (1) 5.] (512)

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 direct care staff are provided training in:

1. falls prevention and management
2. skin and wound care
3. restraints, and
4. continence care and bowel management, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including

any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants:

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On November 5, 2014, at 1:25 p.m. on the first floor across from the nursing station, the Inspector observed that an identified registered staff left the medication cart unattended with the electronic medication administration record (eMAR) screen on, with resident's private health information visible to the public. The registered staff was not in the immediate area. The identified registered staff confirmed that the eMar screen should have been locked when she left the cart.

Observation made by the inspector on November 6, 2014, at 12:30 p.m. on first floor outside of the dining room revealed that the medication cart in the hallway with the eMar screen on, with resident's private health information exposed to anyone passing by. The registered staff was feeding a resident in the dining room. Interview with the DOC-A confirmed that the eMar screen should have been locked prior to the registered staff leaving the medication cart to feed the resident. [s. 3. (1) 11. iv.] (512)

2. On November 10, 2014 at 4:20 pm during medication administration on the first floor, the inspector observed empty medication pouches with residents personal health information visible (name, room number, names of medications prescribed) in a small container on top of the medication cart. The medication pouches were visible to anyone passing by.

Interview with an identified registered staff revealed that the empty medication pouches will remain in the container on top of the medication cart until the end of the shift, when they will be removed to a dedicated container in the medication room. Interview with the DOC-A confirmed that her expectations is the same as what the identified registered staff described. Later the DOC-A indicated that the container with empty resident medication pouches should be kept in the drawer of the medication cart during medication administration, in order to protect residents personal health information. [s. 3. (1) 11. iv.] (596)

WN #6: 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).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of the plan of care for resident #01 indicated that the resident is incontinent of bladder and bowel elimination, he/she is toileted in mornings and changed in bed at other times related to limited mobility and decreased cognitive ability.

Staff interview indicated that the resident cannot sit properly on the toilet and refused to be seated. Staff also indicated that the resident is physically and verbally aggressive to staff. This information is not included in resident #01's plan of care. [s. 6. (4) (a)] (502)

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review indicated that resident #07 is incontinent for bowel elimination and bladder. The individualized toileting plan for the resident requires staff to change the resident in bed after breakfast, lunch, before supper, hs (before bed) and during rounds at nights (included early morning) related to reduced physical and cognitive ability.

A review of documentation from October 31 to November 13, 2014 indicated that resident #07 is not having a brief change as indicated in the plan of care; the resident' brief is not checked or changed in early morning, after lunch or before supper.

Staff interview indicated that resident is changed between 10:00 and 11:00 am, before getting out of bed and once during evening and night shift. [s. 6. (7)] (502)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants:

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Record review of resident #10's post fall documentation related to a November 6, 2014 fall revealed that Head Injury Routine (HIR) was not completed for 72 hours according to the home's Falls Prevention and Management Policy (NUR 04-01-53) dated April 1, 2011. Documentation for November 8, 2014 was missing. Interview with an identified RPN and the DOC-A revealed that Head Injury Routine (HIR) documentation for resident #10 should have be completed for 72 hours post fall, and was not done on November 8, 2014.

Record review of resident #12's post fall documentation related to a October 18, 2014 fall in the dining room revealed that Head Injury Routine (HIR) was not completed for 72 hours according to the home's Falls Prevention and Management Policy (NUR 04-01-53)dated April 1, 2011 and DOC's expectations. Documentation for October 20 and 21, 2014 was missing.

Interview with DOC-A and DOC-C revealed that Head Injury Routine (HIR) documentation for resident #12 should have be completed for 72 hours post fall, and was not done on October 20 and 21, 2014. [s. 30. (2)] (596)

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraint by a physical device is included in the plan of care.

Record review indicated that resident #31 has an identified physical condition with specific symptoms. When the resident is having tremors, the resident is to be put back in bed with both padded side rails up.

Resident is at high risk for falls related to uncontrollable tremors. The resident had tried to get up from the bed when he/she was settled.

Interview with identified staff confirmed that the side rails are being used as a restraint to prevent resident #31 from getting out of bed.

Record review and interview with the RPN confirmed that the use of bed rails as a restraint was not addressed in the resident's plan of care. [s. 31. (1)] (512)

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8 Policies and Records Policies, etc., to be followed, and records

Specifically failed to comply with the following:

8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
(b) is complied with.

Findings/Faits saillants:

1. The licensee failed to ensure that the home's policy was implemented in accordance with all applicable requirements and is complied with.

   Record review of the home's policy entitled Nutrition and Hydration #NCM 02-01-05 and Skin and Wound Care #NCM 02-01-10 directs staff to make a dietary referral when a resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

   Record review of resident #11's plan of care revealed that the resident was not assessed by a registered dietitian until September 22, 2014, while progress notes showed documentation about the alteration to skin integrity and treatment/dressings by registered staff on August 31, 2014.

   Record review of resident #11's progress notes and interview with the RD revealed that the home's policy was not implemented and the RD did not receive a dietitian's referral; hence the resident was not assessed until September 22, 2014 during the regularly scheduled nutrition assessment.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants:

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is

made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Record review and interview with the administrator revealed that an evaluation of the effectiveness of the home's policy to promote zero tolerance of abuse and neglect of residents was not completed in 2013. [s. 99. (b)] (596)

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

On November 5, 2014, an identified staff was observed assisting a resident with feeding in the first floor dining room; the staff placed the spoon on her index finger to probe the food's temperature, then fed the resident.

Interview with staff indicated that the food was served too hot and she was ensuring that the food is at the proper temperature prior to feeding the resident

Interview with the DOC-A indicated that if food is served to residents' too hot, staff should return the food to the dietary staff; she also confirmed that staff should not place residents' food on their finger as it is an infection control issue. [s. 229. (4)] (502)

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Issued on this 4th day of December, 2014
29th day of May 2015

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

[redacted]

Original report signed by the inspector.