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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2016	2015_393606_0021	036071-15	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

JANET GROUX (606), MATTHEW CHIU (565), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 29, 30, 31, 2015, January 4, 5, and 6, 2016.

The following intakes were inspected during this inspection: CSC #001175-14, #008986-15, and #017152-15.

During the course of the inspection, the inspector(s) spoke with the Administrator (A), Administrative Director of Care (A)DOC, Dietitian, Physiotherapist (PT), RAI-MDS Coordinators, House Keeping Manager (HKM), Resident Program Manager (RPM), New Horizon Program Manager (NHPM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Housekeeping Aides (HA), Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the Inspectors conducted observation of Residents and homes areas, medication administration, meal service delivery, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **7 WN(s)**
- **2 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways must be kept locked.

On December 29, 2015, the inspector observed the door leading to a stairway leading to an identified resident home area (RHA) was unlocked and unsupervised. The door was equipped with a maglock, and when the door was pushed open without entering the keypad code, it triggered an audible door alarm.

An interview with the DOC confirmed the above mentioned and the maintenance staff was called to fix the door lock on the same day. [s. 9. (1) 1.]

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 doors leading to stairways must be kept locked, to be implemented voluntarily.

WN #2: 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 are administered to residents in accordance with the directions for use specified by the prescriber.

Record review of a complaint letter from the family of resident #021 addressed to the home on an identified date, reported concerns regarding a number of medication incidents related to the registered staff failing to apply and remove an identified medication to the resident.

Record review of resident #021's electronic medication administration record (e-mar) on an identified date revealed resident is to be administered the medication daily and prior to the administration of this medication, the physician order directs staff to remove the previous medication applied from the day before.

Interview with the SDM revealed that on an identified date, he/she discovered the identified medication, one for the current day and the other one from the day before still on the resident's body. The SDM showed the nurse on duty who confirmed that he/she did not remove the previous day's medication as he/she thought the medication had already been removed.

Interview with RPN #104 and #125 revealed the physician order and e-mar stated that before applying a new dose of the medication, the medication administered from the previous day must be removed.

Interview with RPN #117 revealed he/she administered the medication on the identified date and attempted to look for the medication from the previous day but could not find it. The RPN stated he/she assumed it had already been removed.

Interview with the Administrator revealed the nurse involved in the above incident was an agency nurse and removed from the agency's roster and no longer work in the home. [s. 131. (2)]

2. Record review of a medication incident report regarding resident #021 on the identified date, revealed staff had forgotten to remove the medication from the resident.

Record review of resident #021's e-mar on an identified date, revealed the resident is to be administered the identified medication and remove the medication administered from the previous day before applying the new one.

Interview with SDM revealed that he/she again discovered another medication incident recently finding two of the identified medication on an identified area of the resident's body and brought it to the attention of the RPN who administered the medication.

Interview with RPN #118 revealed he/she administered the identified medication on the identified date, and prior to administering the medication, he/she did not remove the medication from the previous day and does not know why he/she did not do this. The RPN confirmed he/she did not follow the physician's order.

Interview with the Administrator revealed the home completed an investigation and interviewed the RPN and confirmed that the RPN failed to remove the medication administered from the previous day and did not follow the physician's orders. The RPN was counseled by the Administrator on an identified date. [s. 131. (2)]

3. Review of resident #021's medication incident report on an identified date indicated the family reported to the home he/she found the identified medication still on the resident's body, each one on an identified area of the resident's body, one identified with a date and the other without.

Review of resident #021's physician order on an identified date indicated resident to be administered the medication daily and remove previous day's medication before applying the new one.

Interview with the DOC revealed the home completed an investigation and followed up with the RPN involved in the medication error incident who stated he/she did not remember whether he/she had removed the medication prior to administering a new one. The RPN involved received a discipline and was provided education regarding

medication administration. [s. 131. (2)]

4. Review of resident #021's medication incident report on an identified date indicated the family reported to the home resident found two of an identified medication still on an identified area of the resident's body. One of the medication was identified with a date and the other without a date.

Review of resident #021's physician order on an identified date, indicated resident to be administered the identified medication daily. Apply the medication daily, and remove the medication administered from the previous day before applying the new one.

Interview with the DOC revealed the home completed an investigation and followed up with RPN #126 involved in the medication error and the RPN stated he/she was surprised that this incident occurred but does not remember whether he/she had removed the medication administered from the previous day prior to administering the new one. The home confirmed the medication error and followed up with disciplinary action and education with RPN #026 to ensure this incident would not be repeated. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

A review of resident #007's MDS assessment completed on an identified date, indicated that the resident had impaired vision and review of resident's RAP (Resident Assessment Protocol) on an identified date, indicated that the resident did not use glasses and was able to see large prints, pictures, on television due to the aging process. Further review of the resident's written care plan revealed that there was no planned care set out for the resident's vision.

Interview with resident revealed that he/she has a problem with his/her vision and confirmed his/her vision is not good.

Interview with PSW #103 and RPN #104 revealed resident has impaired vision and confirmed there is no plan of care to address his/her impaired vision.

Interview with staff #106 revealed a written care plan should have been developed for the resident's vision. [s. 6. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of Residents' Council (RC) meeting minutes on an identified date, revealed a concern was raised regarding the hours of operation for an identified area in the home and most members were not satisfied because this identified area was often closed. Further review of the meeting minutes on two identified dates, revealed the concern regarding the hours of operation for the identified area was raised by the RC again.

Interview with the RC President (P) and Vice President (VP) indicated that they did not remember receiving the home's response in writing.

Interviews with the RPM and NHPC confirmed a written response was not provided to the RC for the above mentioned concern. [s. 57. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

Record review of a complaint letter from the family of resident #021 addressed to the home on an identified date, reported concerns regarding a number of medication incidents related to an identified medication being applied without the removal of the previous one.

Record review of the home's investigation records did not include a response to the ministry regarding the outcome of the home's investigation.

Interview with the Administrator revealed that the home's understanding is a response is not required for this type of incident and confirmed if a response was sent the ministry would have this information. [s. 103. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review of the home's Continuous Quality Improvement- Medication Management System Evaluation 2014, on an identified date revealed the home's dietitian did not participate in the annual evaluation.

Interview with the Dietitian confirmed that she/he did not participate in the home's 2014 Medication Management System Evaluation held on the above mentioned date. [s. 116. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is kept of everything required under clauses (a) and (b).

Record review of a complaint letter from the family of resident #021 addressed to the home on an identified date, reported concerns regarding a number of medication incidents related to the registered staff failing to apply and remove an identified medication of the resident.

Record review of the home's records regarding the above incident revealed one of the corrective actions taken was to re-educate the staff on medication administration and highlight required medication dispensing steps. No written records were available of the education provided to the staff.

Interview with the Administrator revealed that the education was completed sometime on an identified date, but she/he is unable to find this information and cannot provide it. [s. 135. (2)]

Issued on this 26th day of February, 2016

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

Original report signed by the inspector.