Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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
Dec 13, 2016	2016_397607_0025	032333-16	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

JULIET MANDERSON-GRAY (607), BAIYE OROCK (624), BARBARA PARISOTTO (558), HEATH HEFFERNAN (622), JANET MCPARLAND (142), KAREN MILLIGAN (650), MARGOT BURNS-PROUTY (106)

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): November 21, 22, 23, 24, 25, 28 and 29, 2016.

During the course of this Resident Quality Inspection the following intake was inspected: Log #: 015925-16

Summary of intake:

1) #015925-16: Complaint regarding medication management and care not being provided as per plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator (A), the Director of Care Clinical, Administrative Director of Care (A) DOC, the Resident Program Manager (RPM), the Resident Assessment Instrument - Minimum Data Set (RAI/MDS) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Dietary Aides (DA), Cooks, Personal Support Workers (PSW), Residents and Substitute Decision Makers (SDM).

During the course of the inspection, the inspectors conducted a tour of the home, observed staff to resident interactions, medication administrations, meal service delivery on resident home areas, reviewed clinical health records, staffing schedules/assignment, minutes of the Residents' Council meetings, home specific policies related to Skin and Wound Program and Medication Management.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care

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

2 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 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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care that sets out the planned care for resident #001 related to the use a safety device.

During an observation, on an identified date and time, resident #001’s bed was noted to have two safety device in the up position at the head of the bed.

An interview with resident #001, PSW #132 and RN #131, all indicated that the resident use the safety device for repositioning while in bed. A review of the resident’s current electronic written plan of care failed to identify any planned care related to the use of the safety device.

An interview with DOC #118, indicated that the expectation of the home is, whenever a resident is using a safety device it should be included in the written plan of care for the resident.

The written plan of care failed to identify the planned care for resident #001 related to the use of a safety device. [s. 6. (1) (a)]

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

A complaint was received by the Ministry of Health and Long-term Care Action line on an identified date, regarding laboratory diagnostic test not being completed when residents are admitted to the facility, specifically related to resident #021.

A review of the admissions plan of care and progress notes with an identified date for resident #021, indicated the resident had a diagnosis that would require a specific diagnostic test to be completed. The plan of care also identified that the resident was hospitalized for an identified time period.

According to the clinical health records, resident #021’s attending physician verbally ordered a specific laboratory diagnostic test to be completed on an identified date.

The Physician laboratory orders were written by Registered Practical Nurse (RPN) #115, confirmed with the Physician by RPN #114, had a first check completed by RPN #119 on an identified date and there was no signature noted for a second check by a registered staff.

Interview with RPN #115 on an identified date, indicated that in his/her role he/she performs admission paper work for residents, and had assisted with the admissions orders for resident #021 on an identified date. RPN #115 further indicated that the laboratory service provider, provides laboratory services to resident #021’s home area on a certain day of the week, and the process for processing laboratory orders is as follows: the nurse would receive the order from the physician for the laboratory diagnostic test; a laboratory requisition would be completed by the said nurse that confirmed the physician order; then the resident’s name would be added to laboratory service provider confirmation fax-on site laboratory service form. The form is faxed over to laboratory service provider; and services would have been provided to the residents the next schedule day for the laboratory service provider to come to the home.

Resident #021 was admitted to the home on an identified date and had laboratory

diagnostic test ordered on that same date. Interview with RPN #115 indicated that the laboratory service provider, provided laboratory services to the home on five occasions after the resident's admission. A review of the laboratory service provider confirmation fax-on site lab service forms for resident #021's home area for two identified dates, failed to identify a record of entry for the resident. The earliest entry that was noted on the service form with the resident's name, was a date of three weeks later from the date the physician had ordered the laboratory diagnostic test.

Review of the progress notes on an identified date, indicated that the home received a call from laboratory service provider on an identified date and time, informing the home of resident #021's laboratory test results. The Substitute Decision Maker (SDM) and the physician were notified, and the resident was sent to hospital for further treatment.

Interview with RPN #115 on an identified date, confirmed that the laboratory requisition form was not completed until three weeks later from the date the physician had ordered the test. The RPN further indicated that he/she could not recall how the above identified information was brought to his/her attention and that he/she had spoken to the home area nurse designate (RN#116) at the time, who notified him/her that there was no laboratory test results for the resident. RPN #115 further confirmed that resident #021's name should have appeared on the laboratory service provider confirmation on-site lab service form on a an identified date after admissions, and this was the responsibility of the nurse that confirmed the physician's order.

Interview with the Director of Care of Clinical Services (DOC), indicated the expectation is that lab requisition is to be filled out and laboratory diagnostic test is to be completed for residents on admission or right thereafter.

The licensee failed to ensure that resident #021 had received a laboratory diagnostic test as specified in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that when resident #022's care needs change or care set out in the plan was no longer necessary, the plan of care was reviewed and revised.

Review of resident #022's plan of care on an identified date indicated there were interventions in place for a pressure ulcer.

Interview with Registered Practical Nurse (RPN) #113 on an identified date indicated the

resident no longer had a pressure ulcer and the plan of care was not updated to reflect the healed pressure ulcer.

Interview with RPN #115 on identified date, confirmed that the expectation is the nurses on the units are responsible to update the resident's plan of care and this was not completed.

Interview with the Administrative Director of Care on an identified date indicated that the expectations is that when residents intervention has been resolved the care plan should be updated.

The licensee has failed to ensure that resident #022's plan was revised when the care set out in the plan was no longer necessary specifically related pressure ulcer. [s. 6. (10) (b)]

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 ensuring the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, 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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #022 who was exhibiting a pressure ulcer was reassessed at least weekly by a member of the registered nursing staff.

Review of resident #022's skin assessment records indicated that the resident was identified as having a pressure ulcer to his/her body part. Weekly wound assessment was to be conducted for the resident by using the home’s Weekly Wound Assessment tool. Record review indicated that weekly skin assessments were not conducted for this resident’s body part on three identified dates.

Interview with an RPN #113 and RPN #115 on an identified date, confirmed that the weekly wound assessments had not been completed for the resident, on the above identified dates because the wound champion/nurse was away from the home.

The licensee has failed to ensure that resident #022 who is exhibiting pressure ulcer was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 14th day of December, 2016

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

Original report signed by the inspector.