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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2017	2017_656596_0004	009184-16, 013244-16, 033589-16, 001336-17, 003092-17, 003109-17, 006110-17	Critical Incident System

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), NITAL SHETH (500), SABRINA GILL (662), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, and April 3, 4, 5, 6, 7, 10, 11, 12, 13, 18, 19, 20, 21, 2017.

The following Critical Incident intakes were concurrently inspected: #006873-17 and #007419-17.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator (AA), Acting Administrative Director of Care (AA-DOC), Nurse Practitioner (NP), resident assessment instrument (RAI) coordinator, registered nurse (RN), registered practical nurse (RPN) personal support worker (PSW), social worker (SW), physiotherapist (PT), agency staff and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provided direct care to the resident.

Review of a Critical incident (CI) report submitted to the ministry of health and long term care (MOHLTC) by the home revealed that on a specified date, an identified resident was seen pushing another identified resident causing him/her to sustain a fall.

Review of the first identified resident's plan of care revealed that the resident had responsive behaviours. Interventions for these behaviours included redirecting responsive behaviour by taking resident for walks, talking to resident, taking resident to programs, and to leave resident and return after five to ten minutes if resident resists care.

Interviews with personal support workers (PSW) #110, #115, #116 and #117 reported that staff monitor the first identified resident throughout the shift as he/she had unpredictable behaviour towards other residents and staff. PSW #115 reported that on a specified date, he/she was providing nourishment to residents and last observed the resident and his/her whereabouts at approximately 2015 hours-30 minutes before the above mentioned incident occurred. PSW #115 revealed that the first identified resident's plan of care did not indicate the frequency at which to monitor the resident, however he/she monitored the resident closely.

Registered practical nurse (RPN) #118 and registered nurse (RN) #120 revealed that the interventions for the first identified resident's responsive behaviours included monitoring and this was done by keeping an eye on the resident throughout the shift. RPN #118 stated that he/she usually monitored the resident approximately every 20 minutes throughout the shift. RPN #118 and RN #120 further revealed that the need to monitor the identified resident and the frequency at which to monitor was not included in the resident's plan of care.

An interview with the acting administrative director of care (AA-DOC) revealed that staff were made aware of the need to monitor the first identified resident at the beginning of the shift through verbal report. AA-DOC acknowledged that there was currently no developed intervention to specify the frequency of monitoring for the identified resident and that one should be developed. AA-DOC further acknowledged that the need for monitoring of resident and the frequency at which to monitor was not included in the resident 's plan of care and should be included. [s. 6. (1) (c)]

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

A CI report was submitted to the MOHLTC about an incident that caused an injury to a resident, for which on a specified date, the identified resident was transferred to the hospital.

According to CI report and review of the progress notes, PSW #123 reported to the RN that the identified resident was found during morning care with marked swelling on the body. The identified resident was unable to move the the affected area when asked and

the area was warm and painful to touch. The resident was cognitively impaired and he/she was unable to recall how the area became bruised.The nurse practitioner (NP) assessed the resident and ordered resident to be transferred to hospital. The identified resident was in moderate pain and crying. According to the resident's daughter, the resident was symptom free the night before. The identified resident returned to the home with a fracture.

Interview with PSW #123 revealed on a specified date, he/she was providing a scheduled bed bath to the identified resident. According to the written plan of care the resident required two persons total assistance with the bed bath, and staff to provide all care for the resident. When PSW #123 tried to turn the resident on his/her side, the resident screamed. PSW #124 came to help with the transfer of the identified resident from bed into wheelchair with the mechanical lift, and they both (PSW #123 and #124) noted the swelling and redness on the resident's body. The resident was transported and left to sit at the nursing station. According to PSW #123 he/she was not able to report swelling to the resident's affected area right away when noted, because the night RN who was working until 0700 hrs was not on the unit; the RN was responsible for two units during the night shift. PSW #123 further indicated the night RN usually carried a portable phone for staff to reach him/her, but the PSW did not call the phone as he/she did not consider the concern to be urgent. When the day RN came at 0700 hours, he/she reported the redness and swelling of the affected area on the resident's body.

Interview with AA-DOC revealed the expectation is if PSWs notice changes in the health status of a resident they should report it to registered staff immediately so that the registered staff can complete an assessment and give further directions to PSWs. [s. 6. (4) (a)]

3. The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, if the plan of care was being revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

Review of a CI report submitted to the MOHLTC by the home revealed that on a specified date an identified resident was seen to push another identified resident causing the second identified resident to sustain a fall.

Review of the first identified resident's plan of care revealed that the resident had responsive behaviours. Interventions for these behaviours included redirecting

responsive behaviour by taking resident for walks, talking to resident, taking resident to programs, and to leave resident and return after for five to ten minutes if resident resists care.

Record review of the first identified resident's progress notes indicated that on a specified date in March 2017, the home's behaviour tracking tool (BTT) was initiated for seven days, and one to one monitoring was initiated one day later for 72 hours to monitor the resident's behaviour.

Review of the identified resident's BTT initiated on a specified date in March 2017 for six days, revealed episodes of physical and verbal aggression occurring in the evening hours from 1500 hours to 2200 hours. Documentation on the BTT on the sixth day, revealed the identified resident displayed episodes of physical and verbal aggression in the evening hours.

An interview with PSW #123 revealed that during the one to one close monitoring from over a three day period, the identified resident displayed both physically and verbally aggressive behaviours towards residents and staff. PSW #123 reported that the resident would become aggressive very easily and wander around the unit. PSW #123 further revealed that the resident became upset and aggressive if someone entered his/her room and refused to allow staff help him/her with dressing or personal care. The PSW reported that on his/her last shift with the resident for one to one monitoring on a specified date in March 2017, the resident was verbally aggressive with another identified resident, and when the PSW tried to intervene, the first identified resident turned around and slapped him/her. PSW #123 also reported that the first identified resident's behaviours remained the same from his/her first shift with the resident to the last shift two days later.

Record Review of the first identified resident's progress notes revealed that on another specified date PSW #117 observed the resident punch another identified resident. Progress notes indicated that the other identified resident was frightened and tearful after the incident and no injuries were noted.

Interview with AA-DOC #121 revealed that the first identified resident was still displaying verbal and physical aggression towards staff and other residents when the one to one monitoring was discontinued. He/she further acknowledged that if the one to one monitoring for the resident was in place for a longer period of time the second incident could have been prevented. [s. 6. (11) (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 to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

Review of a CI report submitted to the MOHLTC by the home revealed PSW #108 left an identified resident sitting on the toilet for 30 minutes and forgot to come back to assist the resident.

For the purposes of the definition of "neglect" in subsection 2 (1) of the O. Reg. 79/10, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one of more residents.

A review of the identified resident's written plan of care revealed that the resident was at risk for falls related to unsteady gait and pain. The resident required one to two person

assistance for the physical process of toileting.

A review of progress notes on a specified date revealed at about 0100 hours, RPN #109 heard somebody calling for help and found the identified resident on the toilet; the resident stated that the PSW forgot about him/her and he/she was sitting there for approximately half an hour. The call bell was not within reach. RPN #109 assisted the resident. The identified resident complained about pain and the RPN administered an analgesic.

Interview with PSW #108 revealed that on the specified date referred to above, he/she was doing rounds and the identified resident requested to use the washroom, so PSW #108 assisted the resident onto the toilet. Meanwhile there were two other call bells ringing and PSW #108 went to assist those residents, returning to the identified resident twenty minutes later. He/she went to answer another call bell at the end of the hallway and assisted the resident. Subsequently PSW #108 forgot to go back and assist the identified resident. PSW #108 indicated that he/she did not remember if the call bell was within reach of the resident. The PSW also stated that this was considered neglect as per the definition of neglect in the home's policy on abuse and neglect.

Interview with RPN #109 revealed that on the specified date mentioned above it was not that busy. PSW #108 helped the identified resident onto the toilet, meanwhile PSW #108 came back and asked RPN #109 if he/she could go to other units to find ginger ale for him/herself as he/she was not feeling well. RPN #109 asked the PSW if he/she had completed rounds and PSW #108 indicated that rounds had been completed. RPN #109 allowed the PSW to go and check on other units for ginger ale. All of a sudden RPN #109 heard a voice calling "help me" and found the identified resident on the toilet. The resident reported that "the lady forgot me" and he/she was sitting on the toilet for 30 minutes. RPN #109 assisted the resident back to bed and the resident complained about pain; he/she administered analgesic to the resident. RPN #109 indicated that PSW #108 neglected the identified resident as he/she forgot to go back and provide care to the resident.

Record review of the home's investigation record and an interview with the AA revealed that PSW #108 neglected the identified resident and appropriate actions were taken by the home. [s. 19. (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 residents are protected from abuse by anyone and residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director.

Record Review of an identified resident's progress notes revealed that an incident occurred between two residents on a specified date. PSW #117 observed the first identified resident punch another identified resident. Progress notes indicated that the second identified resident was frightened and tearful after the incident and no injuries

were noted.

Review of the first identified resident's plan of care revealed that the resident had responsive behaviours.

Interviews with PSW #110, #115, #116, and #117 indicated that the home's expectation is zero tolerance for abuse and staff must report witnessed or suspected incidents of abuse to the registered staff on shift. PSW #117 further indicated that he/she reported the incident to RN #120. PSW #110, #115, #116 and #117 stated that the first identified resident's actions posed a risk to the safety of other residents and the above mentioned incident constituted physical abuse.

PSW #117 and RN #120 revealed that after the above mentioned incident, the second identified resident was frightened, tearful and angry. RN #120 further indicated that a progress note and incident report were completed after the incident, and AA-DOC was notified. RN #120 acknowledged that the first identified resident's actions posed a risk to the safety of other residents and the incident constituted physical abuse.

Interviews with AA-DOC and AA indicated that the home's expectation is zero tolerance for abuse and incidents of abuse must be reported to the registered staff or charge nurse who will report to the AA-DOC, then AA- DOC will report to the AA. AA-DOC further indicated that he/she would assist the clinical coordinator (CC) to collect information required to complete the CI report. The AA-DOC was not able to recall if the above mentioned incident was reported to the AA or if a CI report was completed for this incident. He/she acknowledged that the incident mentioned above, between the first and second identified residents constituted physical abuse and should have been reported.

The AA stated that he/she was not aware of the incident between the two residents as it was not reported to him/her. The AA acknowledged that the incident constituted physical abuse and should have been reported and a CI report completed and submitted to the MOHLTC by herself. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of any potential behavioural triggers and variations in resident functioning at different times of the day with respect to the resident.

Review of a CI report submitted to the MOHLTC by the home revealed that on a specified date an identified resident was seen pushing another identified resident causing him/her to sustain a fall.

Review of the first identified resident's plan of care revealed that the resident had responsive behaviours. Interventions included redirecting responsive behaviour by taking resident for walks, talking to resident, taking resident to programs, and to leave resident and return after five to ten minutes if resident resists care.

Interviews with PSW #110, #115 and #116 indicated that the first identified resident had responsive behaviours and triggers for the behaviours included when others removed or used particular items on the unit, and when he/she did not get his/her way. Interviews with PSW #115, RPN #118, and RN #120 further indicated that the above mentioned behavioural triggers were not included in the first identified resident's plan of care.

An interview with AA-DOC #121 revealed that the first identified resident's behavioural triggers included the above mentioned particular items on the unit, and the resident would get upset if the items were used by other residents or staff members. AA-DOC #121 also revealed that the resident was territorial and would get upset if someone entered his/her room. The AA-DOC acknowledged that the above mentioned behavioural triggers were not included in the resident's plan of care and should have been included. [s. 26. (3) 5.]

Issued on this 23rd day of May, 2017

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

Original report signed by the inspector.