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

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

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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
Jun 16, 2017	2017_656596_0005	017785-16, 029963-16, 035302-16, 000485-17, 001167-17, 003857-17	Complaint

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), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint 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 complaint intakes were concurrently inspected: #006749-17, #006889-17 and #006916-17.

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Officer, Acting Administrator (AA), Acting Administrative Director of Care (AA-DOC), Director of Clinical Services (DCS), Nurse Designate (ND), charge nurse (CN), attending physician, resident assessment instrument (RAI) coordinator, registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), registered dietitian (RD), social worker, pharmacist, pharmacy operational manager, physiotherapist, business manager, staffing coordinator, agency staff, community care access centre (CCAC) coordinator, residents and family members.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **1 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident (CI) was submitted to the ministry of health and long term care (MOHLTC) reporting that resident #008 fell to the floor while being transferred by two

personal support workers (PSW) with the mechanical lift. The resident sustained an injury and was transferred to hospital for further assessment.

Interview with PSW #139 revealed that he/she went to the room of resident #008 to help PSW #138, who was the primary care giver to the resident, with a transferring the resident. According to PSW #139, PSW #138 mentioned that the resident was exhibiting responsive behaviours while providing care before 0700 hours. PSW #139 indicated that while preparing the resident for transferring and providing care, the resident acted out towards PSW #139. PSW #139 continued to maneuver the mechanical lift it and moved the lift towards the resident's wheelchair that was located one to two feet away from the bed's footboard. The resident was not well positioned on the lift and the two PSWs proceeded with the transfer, and while pushing the lift towards the wheelchair the resident fell on the floor, injuring his/herself. When PSW #139 noted the resident was falling he/she tried to save the resident but could not.

A review of resident #008's written plan of care revealed interventions related to provision of care, how to approach the resident, and how to re-approach, if necessary to avoid responsive behaviours.

Interview with PSW #139 revealed they did not follow the interventions as specified in the plan of care, partly due to a language barrier.

Interview with PSW #138 revealed when resident #008 presented with responsive behaviours staff would leave him/her in bed and notify the registered staff. Observation of the inside door of the resident's closet revealed a translation of most commonly used words in his/her first language.

Interview with PSW #125 revealed he/she always explains to the resident in his/her first language when providing care, and this helps substantially with the resident's behaviour. When the resident is resistive to care staff should leave and approach later when he/she calms down.

Interview with resident #008's family member revealed the resident may exhibit responsive behaviours if woken up prior to his/her regular morning routine.

Interview with PSW #139 revealed resident #008 should have been left in bed when he/she presented with responsive behaviours. This was confirmed by the acting administrator. PSW #138 was assigned to a different floor and retrained on safe

transfers. [s. 36.]

2. Record review of a CI report submitted to the MOHLTC revealed that resident #001 was transferred from wheelchair to bed by PSW #103. When in bed, the resident began to complain about pain, the registered practical nurse (RPN) assessed and analgesic was administered to the resident. The next day the physician assessed resident #001 and ordered for him/her to be transferred to hospital for further assessment; The resident returned to the home from hospital with diagnosis of an injury.

Record review of resident #001's plan of care under the transferring section directed staff to use a specified lift with two person assist.

Record review of the home's investigation notes and interviews with PSW #103 and the AA revealed that the PSW transferred the resident by himself/herself, using a pivot transfer from wheelchair to bed. After being transferred to bed, the resident then began to complain of pain. PSW #103 and the AA confirmed that the PSW did not follow the resident's plan of care and two staff should have transferred resident #001, as indicated in the resident's care plan. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has 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 were integrated, consistent with and complement each other.

A CI report was submitted to MOHLTC reporting that resident #008 fell while being transferred by two PSWs with the mechanical lift. The resident sustained an injury.

Interview with PSW #138 revealed he/she notified the registered nurse (RN) about the fall after the resident was transferred from the floor to the wheelchair using the same mechanical lift.

Interview with PSW #139 revealed resident #008 fell on the floor and hit an identified body part. PSW #139 and #138 assisted the resident and transferred him/her to the wheelchair. After the resident was positioned in the wheelchair PSW #139 called the RN to inform him/her about the resident's fall.

A review of the home's policy titled Falls Prevention and Management program, #05-02-02, dated November 2014, revealed a head to toe assessment will be completed after un-witnessed falls and falls where residents report that he/she hit the head during the fall.

Interviews with the acting administrative director of care (AA-DOC) and RN #140 revealed the expectation is if a resident is on the floor, the PSWs should leave the resident in the same position and call registered staff to complete an assessment. The resident should be repositioned or further transferred only under the direction of the registered staff, and they confirmed that in this case, the RN was notified about the fall after the resident was moved or transferred to the wheelchair. [s. 6. (4) (a)]

2. A complaint was submitted to the MOHLTC reporting that resident #006 fell resulting in an injury.

A review of resident #006's clinical record revealed the resident was transferred to hospital on a specified date in January 2017, for treatment of an injury and a medical condition. Five days later the resident returned to the home, the next day the physician ordered a particular diagnostic test every six hours for three days and prescribed medication. Progress notes on a specified date in February 2017, indicated that RN #126 contacted another physician to clarify the order because it was not clear why it was ordered, and the above mentioned diagnostic test was discontinued. The physician ordered for the resident's condition to be monitored. On a subsequent specified date in February 2017, resident #006 was transferred to hospital again for treatment of a medical condition; the resident returned to the home four days later. The home's form titled Return to Long Term Care from Hospital revealed documentation that a procedure was completed in hospital and the resident to be monitored.

A review of the progress notes revealed documentation by registered staff that the resident was monitored once after the first physician order after the first hospitalization, and was monitored twice after the second hospitalization.

Interview with RN #127 and AA-DOC revealed that there was no documentation that the resident was monitored after the first return from hospital in February 2017, and that if it was not clear how to monitor and document and for how long.The registered staff should have contacted the physician who prescribed the order to clarify. [s. 6. (7)]

3. A CI report was submitted to the MOHLTC by the home, and a complaint from a family member was called into the MOHLTC Infoline regarding resident #037 sustaining injuries of unknown cause.

A review of resident #013's clinical record revealed he/she required total care in all areas of personal care and activities of daily living (ADL).

According to resident #013's progress notes on a specified date in March 2017, it was reported to RPN #120 by PSW #134 that when the resident was transferred into bed, he/she noticed swelling on the resident's limb. The next day the Nurse Practitioner (NP) assessed the resident and documented findings that the resident had swelling and discoloration to a limb. The resident was transferred to hospital for further assessment and returned the same evening after being treated for an injury.

Interview with PSW #131 revealed on an identified date in March 2017, he/she transferred resident #013 from bed into wheelchair. PSW #131 indicated that he/she noticed a discolored area to the resident's limb while he/she was still in bed, and transferred the resident with PSW #151 into the wheelchair; it was then reported to RPN #120.

Interview with RPN #120 revealed he/she assessed resident #013's limb with the physician and no change in skin color was noted. On assessment RPN #120 noted discolorations to the resident's body. The physician ordered an x-ray and it confirmed an injury.

Interview with PSW #131 revealed he/she did not report the changes of resident #013's limb while the resident was still in bed because the registered staff and PT were around and aware of it. Interview with the PT and RPN #120 revealed they were not informed of the skin color changes to the resident's body until the resident was in the wheelchair.

Interview with RPN #120 confirmed if PSWs noted the skin color changes to the resident's body they should have notified the nurse right away for immediate assessment, and confirmed that it was not reported to him/her.

A review of the flow sheets in point of care (POC) revealed a sign off by PSW #152 that resident #013 was provided with bathing by one staff on the evening of a specified date in March 2017.

Interview with PSW #152 who documented in POC revealed he/she did not provide the bath to the resident, and that it was wrongly documented.

Interview with PSW #148 revealed he/she bathed the resident, with two person

assistance for transfer and one person during bathing.
Interview with PSW #145 revealed resident #013's plan of care specified the type of bathing resident #013 was to receive.This type of bathing was different from that which PSW #148 provided.

A review of the written plan of care, under the the bathing section revealed resident #013 requires one to two staff assistance during specified type of bathing. A review of the short form of the written plan of care/kardex did not indicate the section that resident #013 required bed bath.

Interview with PSW #148 confirmed he/she did not bathe resident #013 as per the written plan of care, he/she did not check the full version of the care plan and it was not in the Kardex. Interview with the AA confirmed if the resident was assessed to require a specified type of bathing the staff should have followed the plan of care. [s. 6. (7)]

4. A complaint was received by the MOHLTC regarding short staffing levels in the home.

Record review of the home's staffing schedule with staffing coordinator #142 revealed that an identified home area worked short one PSW staff on the day shift, on March 12, 2017.

Record review of the resident bath list for the identified home area and the POC task indicated that resident #012's bathing days were two identified days of the week.

Record review of resident #012's POC documentation did not include bathing sign off documentation for an identified day in March 2017.

Interview with PSW #146 reported that he/she was supposed to bathe resident #012 on the above mentioned identified day in March 2017, day shift and was not able to, as they worked short one PSW on the day shift, and the position had not been filled. The PSW stated that he/she could not remember informing the nurse about the resident's missed bath.

Interview with RPN #143 reported that he/she remembered PSW #146 telling him/her about working short staffed on the above mentioned date but no report was made about not being able to complete resident #012's bathing. During interview RPN #143 reminded PSW #146 of the home's expectation that PSW staff report missed resident baths to the nurse on duty, so that it can be documented as care not given and rescheduled.

Interview with RN #111 reported that the home's expectation is that in the event that staff work short and staff are unable to complete all scheduled resident shower/baths, then a bed bath should be offered to the resident. If unable to get a bed bath done then bathing will be completed the next shift or day. PSWs are expected to report it to the unit charge nurse when care set out in the plan of care is not provided. [s. 6. (7)]

5. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care and have convenient and immediate access to it.

A CI report submitted to the MOHLTC reported that resident #008 had a fall on an identified date in March 2017. A review of the written plan of care indicated the resident had a preferred wake up time.

Interview with PSW #138 revealed on the above mentioned specified date in March 2017, resident #008 was given morning care and transferred from the bed to wheelchair earlier than his/her preferred wake up time. The PSW revealed that there was no consistency in the time when resident #008 was being assisted to get up, and it would depend on how busy staff were or when other staff were available to help.

Interview with PSW #128 revealed the written plan of care for residents is kept in a binder and locked in the nursing room.

Interview with the AA-DOC revealed residents' written plan of care are located in the computer and the short form (kardex) is located in POC. PSW #138 was not able to demonstrate to the inspector that he/she had convenient and immediate access to the written plan of care for resident #008 or other residents.

Interview with PSW #139 revealed he/she had access to the short form of the care plan (kardex) but not to the long form of the care plan. PSW #139 indicated she was not trained how to open the full care plan. [s. 6. (8)]

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 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, that the care set out in the plan of care is provided to the resident as specified in the plan, and that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 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 applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee of the home has failed to ensure that 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 is complied with.

A review of resident #006's clinical record indicated the physician prescribed a particular medication on a specified date in February 2017, one dose to be given the same day, and as needed (PRN). A review of the electronic medication administration record (eMAR) revealed the physician's order for the PRN medication was transcribed in the eMAR on the above mentioned specified date, the order for the medication to be given on the same day was not transcribed in the eMAR. A review of the progress notes revealed on a specified date in February 2017, registered staff administered the above mentioned medication with positive effect and documented in the progress notes but not in the eMAR.

A review of the policy titled Requirements for Prescription and Non-Prescription Medications, Purchasing and Handling of Drugs, policy #TC-1014, procedures #TC-PR-1014, dated February 15, 2015, revealed non-prescription (i.e., over-the-counter) medications contain active ingredients that may cause side effects, adverse reactions, or interactions with other medications. Therefore, it is important that the facility, physician/prescriber, and pharmacy are aware of all medications taken by the resident, and that the use of non-prescription medications is well documented in the resident's medication record.

Interview with RD revealed when he/she assessed resident #006 on a specified date in February 2017, post-hospitalization, he/she reviewed an identified flow sheet; he/she then checked the eMAR and noticed a particular medication was not administered as ordered on the specified date in February 2017 mentioned earlier.

Interview with the AA-DOC revealed the practice is every physician's order must be transcribed in the eMAR, and when medication is administered to a resident, it is to be signed by registered staff- it was not done in this case. [s. 8. (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 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 is complied with, to be implemented voluntarily.

WN #4: 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 were administered to residents in accordance with the directions for use specified by the prescriber.

Record review of a complaint from a family member to the MOHLTC infoline reported to the home that resident #004 was over-medicated on a specified date in December 2016, for the sixth time. Previous similar occurrences were inspected by the MOHLTC and non-compliances left. Record review of a letter of complaint from the family member sent to the home revealed that on a specified date in December 2016, a family member discovered a medication error.

Interview with the complainant confirmed the same and that the medication should be applied as per the physicians order.

Record review of resident #004's physician order summary report dated October 26, 2016, revealed an order for a particular medication.
Record review of resident #004's medication administration record (MAR) for December 2016 revealed all staff had signed as completed for removing the medication at 0759 hours and applying the new one at 0800 hours.

Record review of the medication incident report, the home's investigation notes and interview with the AA revealed that RPN #108 from the agency worked on the above mentioned specified date in December 2016 day shift and did not remove resident #004's prescribed medication in the morning before applying the new one as prescribed, resulting in a medication error. The RPN signed on the resident's eMAR for removing the medicatioon and applying the new one in December 2016. The AA revealed that after this medication incident, the home requested that the agency not send RPN #108 back to work at the home, and he/she hasn't worked at the home again.

Interview with RPN #108 revealed that he/she was sent to work at the home by the agency on the above mentioned specified date in December 2016, and was not informed that he/she had made a medication error. [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 184. Withdrawal of approval by licensee

Specifically failed to comply with the following:

s. 184. (2) If information provided to the licensee by the placement co-ordinator indicates that there has been a change in the applicant's condition and, as a result, a ground for withholding approval mentioned in subsection 44 (7) of the Act exists, the licensee may withdraw the approval of the applicant's admission to the long-term care home in accordance with paragraphs 1 and 3 of subsection 44 (14) of the Act. O. Reg. 79/10, s. 184 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that it did not withdraw approval of an applicant's admission unless it had information provided to it by the placement co-ordinator that indicated that there had been a change in the applicant's condition and, as a result, a ground for withholding approval mentioned in subsection 44 (7) of the Act exists.

According to subsection 184(1) , subsection 184(2) applies where a licensee has approved an applicant's admission to the home and the applicant's admission has not yet been authorized by the placement co-ordinator.
According to subsection 44 (7) of the Act, the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;

(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44 (7).

A complaint was received at the MOHLTC infoline from resident #007's family member in regards to unsuccessful admission to the LTC home.

According to the home's social worker (SW), on a specified date in June 2016, the resident and several family members came to the home with the intention that the resident would be admitted, however the resident did not seem prepared to stay. After the home tour on an identified unit and resident being told that he/she was going to stay in the home, he/she became agitated exhibiting responsive behaviours. The Substitute Decision Maker (SDM) did not sign the admission documents.
The home requested the physician who was in the home on another unit to assess the resident. Interview with the physician who had assessed the resident revealed he/she visits the home once a week and it was not common practice to be called for new admissions. The physician indicated that he/she had discussed with the SW and the family members that the resident presented as being capable for making his/her own decisions, because the resident became agitated when told to stay. The physician reported not having the resident's CCAC assessments available to know the history and previous diagnoses of the resident.

The SW indicated she discussed with the applicant's family that resident #007 needed further assessment and referred them to external resources. After the family left the home the SW shredded the admission package from CCAC and called them with notification that the resident was not admitted at the home. He/she informed the CCAC that the resident was seen by two physicians, deemed capable for his/her own decisions, and did not want to stay in the LTC home.

In an interview with the CCAC placement coordinator the inspector was told that the resident was reassessed again by CCAC after the non-admission to the home and deemed incapable again. The coordinator revealed they did not provide the licensee any new information about the resident.

According to the family, the home overruled the CCAC decision for resident #007's eligibility for admission to the LTC home.

Interview with CCAC revealed the bed was offered to another client who was on the waiting list and was later admitted to the home on a specified date in June 2016.

The licensee withdrew approval of resident #007's admission before the CCAC had authorized admission. The withdrawal of approval was not because of one of the grounds listed in s. 44(7) of the Act, as none of those grounds existed. The home’s explanation of why the resident was not admitted was because the resident's family did not sign the admission package. This explanation was contradicted by what the inspector was told by the resident's SDM and the placement co-ordinator. The resident's SDM told the inspector that the resident was not admitted because he/she was assessed by the home's two physicians, and that he/she was deemed capable to decide, was not willing to stay, and was not eligible for an identified unit.
The CCAC placement co-ordinator told the inspector that the resident was not admitted because the SW informed CCAC about the same reasons as stated by the SDM, and the resident exhibited threatening responsive behaviours.

The licensee did not have a basis to withdraw approval based on the assessment and information provided by the CCAC. [s. 184. (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 if information provided to the licensee by the placement co-ordinator indicates that there has been a change in the applicant's condition and, as a result, a ground for withholding approval mentioned in subsection 44 (7) of the Act exists, the licensee may withdraw the approval of the applicant's admission to the long term care home in accordance with paragraphs 1 and 3 of subsection 44 (14) of the Act. O. Reg. 79/10, s. 184 (2).
If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval;
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
(c) an explanation of how the supporting facts justify the decision to withhold approval; and
(d) contact information for the Director. 2007, c. 8, s. 44 (9).
Persons to whom notice given
(10) The persons referred to in subsection (9) are the following:
1. The applicant.
2. The Director.
3. The appropriate placement co-ordinator. 2007, c. 8, s. 44 (10), to be implemented voluntarily.

WN #6: 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, were documented.

A review of resident #006's written care plan for continence indicated the resident was incontinent. The care plan included interventions for the staff to implement. The resident required one person constant supervision and physical assist (extensive assistance) for safety, related to the resident's incontinence. The resident was at risk for falls. An identified intervention was initiated on a specified date in April 2016, and a second intervention was initiated in November 2015; the resident declined this intervention.

A review of resident #006's bladder and continence assessment dated October 25, 2015, revealed the resident required assistance with toileting, toileting pattern was to use the toilet at day, evening and night time. The frequency of toileting was one to two times per shift, and to use a particular sized incontinent product. The resident was able to find the toilet, was motivated to be continent and had the preference to be toileted.

A review of the home's policy titled Continence Care Program, Urinary -Continence Screening, Policy #02-04-03, dated August 2010, revealed after seven days continence screen, the level of continence is determined and a plan of care in response to the pattern of continence is developed and documented. The care plan will include: the resident's level of continence, frequency of toileting and individual patterns of toileting, retraining strategies and interventions, factors contributing to incontinence such as coughing, sneezing, etc., difficulty with verbalizing the need to void.

A review of the quarterly minimum data set (MDS) assessments in April, July, and October 2016 revealed the resident was frequently incontinent.

Interview with PSW #125 revealed that resident #006 was assisted with toileting at least three times a shift, such as before and after meals and before going to bed. Before the fall on a specified date in January 2017, the resident was able to walk but was unstable, was cognitively impaired and was not able to ask for help. If staff would notice the resident walking they would ask him/her if he/she needed to go to the toilet and assist. The resident had a specified intervention in place because he/she was not able to call for help and to notify staff when attempting to go to the washroom.

Interview with resident #006's family member revealed the resident attempted to go to washroom unassisted and that was why the resident had the intervention in place.

Interview with registered staff #126 revealed the toileting routine of resident #006 was not documented in the written plan of care and after the discussion with the inspector he/she updated it accordingly. [s. 30. (2)]

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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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 every medication incident involving a resident and every adverse drug reaction is reported to the pharmacy service provider.

Record review of the home's pharmacy policy titled Medication Incident Reporting and Follow-up, next review date Feb 15, 2016, directed the home to complete a medication incident report for every medication incident involving a resident, and notify the pharmacy service provider.

Record review of a complaint by a family member called into the MOHLTC infoline, reported that resident #004 was over medicated on specified date in December 2016. Interview with the family member confirmed the same as mentioned above.

Record review of resident #004's physician's order summary report for a specified date in October 2016 revealed an order for a particular medication.
Record review of a medication incident report on a specified date in December 2016, revealed resident #004's family member reported that the resident was discovered with two doses of medication on at 2020 hours-one labelled with a date and the other one wasn't.

Interview with the AA reported that a medication error occurred on a specified date in December 2016, when RPN #108 from an agency worked on the day shift and applied resident #004's medication, without removing the old one. The AA could not confirm if pharmacy was notified and the medication incident report faxed.

Interview with the home's pharmacist consultant and pharmacy operational manager confirmed that the medication error involving resident #004 that occurred on a specified date in December 2016, was not reported to the pharmacy as expected and outlined in the pharmacy's medication incident reporting and follow up policy. The pharmacist consultant stated that he/she has reminded the home that all medication errors involving residents should be reported to pharmacy. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

Record review of a complaint from a family member to the MOHLTC infoline reporting that resident #004 was over-medicated on a specified date in December 2016, for the sixth time. Previous similar occurrences were inspected by the MOHLTC and non-compliances left. Record review of a letter of complaint from the family member sent to the home in December 2016, revealed a family member discovered a medication error.

Interview with the complainant confirmed the same and stated that the resident should have only one medication on at a time, with the previous one removed before a new one is applied each morning, as per the physicians order.

Record review of the home's quarterly medication incident analysis for November 3, 2016 to January 2017, did not include the medication error involving resident #004 in December 2016.

Record review of a medication incident report on a specified date in December 2016, the home's investigation notes, and interview with the AA confirmed that RPN #108 from an agency did not administer the medication as per physician's order.

Interview with the home's consultant pharmacist and pharmacy operational manager revealed that the medication incident involving resident #004 was not included in the home's medication analysis report, nor reviewed and analyzed at the home's quarterly PAC meeting on January 17, 2017, and the home did not fax the medication incident to the pharmacy as outlined in the pharmacy policy titled medication incident reporting and follow up. The pharmacy operational manager stated that a fax had been received by the pharmacy from the home of resident #004's medication incident report just yesterday during the time inspectors were in the home.

Interview with the AA could not confirm that resident #004's medication incident report on a specified date in December 2016, was faxed to pharmacy and reviewed and analyzed as required.

The home has previously been issued a voluntary plan of correction (VPC), under O.Reg 79/10, s. 131(2) within report # 2015_393606_0021 on February 25, 2016.The report details medication errors involving resident #004 when staff did not remove the previously applied medicated prescribed patch before applying a new one daily on specified dates in June and October 2013, February 2014 and December 2015.

Record review of the home's voluntary plan of correction (VPC) for the above mentioned RQI non-compliances outlined under the long term action section that regular audits and monitoring to continue.
Record review of the home's audits from December 29, 2016 to present revealed no record of audits from December 29, 2016 to January 12, 2017.

Interview with the AA and AA-DOC confirmed that the personal checks mentioned in the response letter to the complainant were done by both of them, and served as part of the audits and monitoring outlined in the home's VPC . Audits were still ongoing to ensure no further medication incidents with resident #004's medication administration. The home was unable to locate written records of resident #004 patch administration audits from

December 29, 2016 to January 12, 2017. [s. 135. (2)]

Issued on this 27th day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA BERDOE-YOUNG (596), NITAL SHETH (500), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2017_656596_0005
Log No. / Registre no:	017785-16, 029963-16, 035302-16, 000485-17, 001167-17, 003857-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 16, 2017
Licensee / Titulaire de permis :	VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC. 10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0
LTC Home / Foyer de SLD :	VILLA COLOMBO SENIORS CENTRE 10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0
	Lyana Nava

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

To VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to:

1. Ensure that all staff who provide direct care to residents receive education on safe transferring and positioning devices and techniques when assisting residents.
The education shall include the following:
-Attendance sheet for staff who received the education with their name, title and date when they received the education
-Include all full-time, part-time, casual and new hire staff as of the compliance date.

2. Update the written plan of care of all residents exhibiting responsive behaviours with individualized interventions to ensure safe transferring and positioning devices or techniques are used.

The plan to be submitted via email to theresa.berdoe-young@ntario.ca by September 27, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Record review of a critical incident (CI) report submitted to the ministry of health and long term care (MOHLTC) revealed that resident #001 was transferred from wheelchair to bed by personal support worker (PSW) #103. When in bed, the resident began to complain about pain, the registered practical nurse (RPN) assessed and analgesic was administered to the resident. The next day the

physician assessed resident #001 and ordered for him/her to be transferred to hospital for further assessment; the resident returned to the home from hospital with a diagnosed injury.

Record review of resident #001's plan of care under the transferring section directed staff to use a specified lift with two person assist.
Record review of the home's investigation notes and interviews with PSW #103 and the acting adminstrator (AA) revealed that the PSW transferred the resident by himself/herself, using a pivot transfer from wheelchair to bed. After being transferred to bed, the resident then began to complain of pain.

PSW #103 and the AA confirmed that the PSW did not follow the resident's plan of care and two staff should have transferred resident #001 from wheelchair to bed, as indicated in the resident's care plan.
(596)

2. A CI was submitted to the MOHLTC reporting that resident#008 fell to the floor while being transferred by two PSWs with the mechanical lift. The resident sustained an injury and was transferred to hospital for further assessment.

Interview with PSW #139 revealed that he/she went to the room of resident #008 to help PSW #138, who was the primary care giver to the resident, with transferring the resident. According to PSW #139, PSW #138 mentioned that the resident was exhibiting responsive behaviours while providing care before 0700 hours. PSW #139 indicated that while preparing the resident for transferring and providing care, the resident acted out towards PSW #139. PSW #139 continued to maneuver the mechanical lift and moved it towards the wheelchair that was located one to two feet away from the bed's footboard.The resident was not well positioned on the lift and the two PSWs proceeded with the transfer, and while pushing the lift towards the wheelchair the resident fell on the floor, injuring his/herself. When PSW #139 noticed the resident was falling he/she tried to save the resident but could not.

A review of resident #008's written plan of care revealed interventions related to provision of care, how to approach the resident, and how to re-approach, if necessary to avoid responsive behaviours.

Interview with PSW #139 revealed they did not follow the interventions as specified in the plan of care, partly due to a language barrier.

Interview with PSW #138 revealed when resident #008 presented with responsive behaviours staff would leave him/her in bed and notify the registered staff. Observation of the inside door of the resident's closet revealed a translation of most commonly used words in his/her first language.

Interview with PSW #125 revealed he/she always explains to the resident in his/her first language when providing care, and this helps substantially with the resident's behaviour. When the resident is resistive to care staff should leave and approach later when he/she calms down.

Interview with resident #008's family member revealed the resident may exhibit responsive behaviours if woken up prior to his/her regular morning routine.

Interview with PSW #139 revealed resident #008 should have been left in bed when he/she presented with responsive behaviours. This was confirmed by the AA. PSW #138 was assigned to a different floor and retrained on safe transfers. (210)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 27, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa Berdoe-Young

Service Area Office /
Bureau régional de services : Toronto Service Area Office