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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 9, 2018	2018_644507_0007	011512-17, 021286-17	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 (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

STELLA NG (507)

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): February 28, March 1, 2 & 5, 2018.

The following intakes were completed during this critical incident system inspection:

- Log #011512-17, CIS #2969-000017-17 was related to falls, and
- Log #021286-17, CIS #2069-000032-17 was related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care - Administrative (DOC-A), Charge Nurse (CN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs),Physiotherapist (PT), Housekeeping Aide (HA) and residents.

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A) An identified critical incident system (CIS) report with an identified date received through the CIS, stated that resident #012 experienced a fall on an identified date, and the fall caused an injury to resident #012 for which the resident was taken to hospital on the same day, and which resulted in a significant change in the resident's health status.

Review of the above mentioned CIS and progress notes of resident #012 revealed that resident #012 experienced a fall on the above mentioned identified date. During assessment, resident #012 complained of pain and discomfort. Resident #012 was sent to the hospital for further assessment. Review of the progress notes of resident #012 revealed an entry on the next day by staff #111 that the home received information from

the hospital revealing resident #012 sustained an injury.

During interviews, staff #111 and #112 acknowledged the home had been aware of resident #012's injury on the identified date, and failed to inform the Director until nine days later.

B) An identified CIS report with an identified date received through the CIS, stated that resident #011 experienced a fall on an identified date, and the fall caused an injury to resident #011 for which the resident was taken to hospital on the same day.

Review of the above mentioned CIS and progress notes of resident #011 revealed that resident #011 experienced a fall on the above mentioned identified date. During assessment, resident #011 was noticeably in pain. Resident #011 was sent to the hospital for further assessment. Review of the progress notes of resident #011 revealed an entry on the next day by an identified staff member that the home received information from the hospital revealing resident #011 sustained an injury.

During interviews, staff #111 and #112 acknowledged the home had been aware of resident #011's injury on the identified date, and failed to inform the Director until eight days later.

C) Record review of the progress notes of resident #011 revealed that resident #011 experienced a fall on another identified date. During assessment, resident #011 complained of pain. Resident #011 was sent to the hospital for further assessment.

Record review of the progress notes of resident #011 and the transfer checklist return to Long Term Care from Hospital document revealed resident #011 returned to the facility the next day and sustained an injury from the fall.

Review of the CIS submission from the home failed to reveal a CIS in regards to resident #011's fall which occurred on the identified date that caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in resident #011's heath status. During an interview, staff #111 confirmed the home did not submit a CIS related to resident #011's above mentioned incident.

D) As a result of identified noncompliance with Ontario Regulation (O. Reg.) 79/10, s. 107 (3), the sample of residents inspected related to informing the Director no later than one business day after the occurrence of an incident that caused an injury to a resident

that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital was expanded to include resident #013.

An identified CIS report with an identified date received through the CIS, stated that resident #013 experienced a fall on an identified date, and the fall caused an injury to resident #013 for which the resident was taken to the hospital on the same day.

Review of the identified CIS and the progress notes of resident #013 revealed that resident #013 experienced a fall on the identified date. During assessment, resident #013 was noticed having discomfort. Resident #013 was sent to the hospital on the same day. Review of the progress notes of resident #013 revealed an entry on the same day by an identified staff member that the home received information from the hospital that resident #013 sustained an injury.

During interviews, staff #111 and #112 acknowledged the home had been aware of resident #013's injury on the identified date, and failed to inform the Director until 10 days later.

The Director was not informed no later than one business day after the occurrence of incidents of residents #011, #012 and #013 that caused injuries to the residents that resulted in a significant change in the residents' health condition and for which the residents were taken to a hospital. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

An identified CIS report with an identified date received through the CIS, stated that resident #012 experienced a fall on an identified date, and the fall caused an injury to resident #012 for which the resident was taken to the hospital on the same day, and which resulted in a significant change in the resident's health status.

Record review of the progress notes of resident #012 revealed that the resident experienced another fall one month later, and sustained altered skin integrity, as confirmed during an interview with staff #111.

Interviews with staff #102, #108, #110 and #111 verified that a post-fall assessment using the morse fall scale template was to be conducted electronically when a resident has fallen.

Record review of the assessments of resident #012 failed to reveal a morse fall scale assessment completed on the above mentioned identified date, as confirmed during an interview with staff #111.

A post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls when resident #012 has fallen on the identified date. [s. 49. (2)]

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Issued on this 19th day of March, 2018

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

Original report signed by the inspector.