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 prévue le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 09, 2018;	2018_642606_0002 (A1)	024766-17, 027953-17, 000175-18	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 (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

STELLA NG (507) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendments have been made to WNs #1 and #2.

Issued on this 9 day of March 2018 (A1)

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

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

STELLA NG (507) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 26, 29, 30, 31, February 1, and 2, 2018.

Complaint related to the management of resident's care and home's admission and discharge procedures.

Two Critical Incidents (CI) related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Administrative Director of Care A(DOC), the Infection Prevention and Control (IPAC) Nurse, Attending Physician, Manager, York Region Public Health, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Staff, Activation Staff, Staff Relief Agency PSW, Mackenzie Health and Leap of Faith Together (LOFT) PSW, families, and Residents.

During the course of the inspection the inspectors observed resident care, observed staff and resident interactions, observed infection control staff practices, interviewed staff and Substitute Decision Makers (SDM), reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 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 :

(A1)
1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Review of a Critical Incident (CI), indicated on identified date and time, a Personal Support Worker (PSW) witnessed resident #001 beside resident #003 at an identified location with resident #001 interacting with resident #003 in an identified manner.

Review of resident #003's clinical records indicated that resident #003 had identified medical and physical conditions.

Review of resident #001's clinical records indicated resident #001 had identified medical conditions and identified responsive behaviours.

Review of resident's #003 progress notes on an identified date and time indicated that resident #003 was in an identified area of the home and a PSW #114 witnessed resident #001 interacting with resident #003's in an identified manner. The progress notes indicated that PSW #114 reported that they immediately called resident #001 by their name and that the resident immediately stopped interacting with resident #003 and indicated that resident #001 than left the area and went to an identified area of the home.

Review of resident #001's progress notes indicated that they were admitted on an identified date and time and was noted to have identified responsive behaviours prior to being admitted to the home. Further review of the resident's progress notes indicated that there had been a CI involving resident #001 and resident #002 prior to the incident between resident #001 and #003. The progress notes indicated that an identified number of days after the resident was admitted, the resident had

approached resident #002 while the resident had been in an identified state in an identified area of the home and had displayed an identified responsive behaviour towards resident #002. Further review of the progress notes indicated the home submitted this incident to the MOHLTC as an abuse incident.

Interview with PSW #114 Indicated resident #003 had identified medical conditions and required staff to provide all aspect of their care. The PSW indicated that on an identified date and time, they witnessed resident #001displayed an identified behaviour towards resident #003. The PSW indicated that resident #003 was in an identified state as resident #001 interacted with resident #003. Resident #003 did not consent to the interaction.

Interview with the Administrator on an identified date indicated that the home had a number of interventions in place to manage resident #001's responsive behaviours. During the interview, when the inspector indicated two incidents occurred on two identified dates between resident #001 and #003, the Administrator acknowledged the incidents had occurred.

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 were protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of a CI on an identified date and time indicated resident #001 was found in an identified area of the home and witnessed by a PSW interact with #002 in an identified manner. Review of another CI on an identified date and time, indicated that a PSW witnessed resident #001 interact with resident #003 in an identified manner.

Review of resident #001's clinical records indicated resident #001 had identified medical conditions and identified responsive behaviours.

Review of an identified assessment on an identified date indicated resident #001's had displayed identified responsive behaviours prior to being admitted to the home.

Review of resident #001's plan of care on an identified date identified resident #001 to have identified responsive behaviours and required staff to provide identified interventions to manage the resident's identified responsive behaviours.

Review of resident #001's progress notes on identified dates, leading up to the incident with resident #003 on an identified date, indicated resident #001 had displayed identified responsive behaviours during identified times. The progress notes indicated that resident #001 was often in an identified state during an identified time and had displayed identified responsive behaviours towards identified residents during these times and indicated resident #001 had displayed an identified responsive behaviour when redirected by staff. Further review of the progress notes indicated that during identified dates and time prior to the day of the incident with resident #003, resident #001 continued to exhibit identified responsive behaviors towards identified residents and had been difficult to redirect.

Further review of the progress notes on an identified date indicated that an identified intervention was discontinued and replaced with an identified intervention based on identified assessments completed by identified members of the multidisciplinary team and indicated that a reassessment was to be completed after an identified time after the identified intervention had been completed. The progress notes further indicated that identified interventions as mentioned in the plan of care was to continue and additional identified interventions were to be initiated.

The progress notes indicated the identified responsive behaviours continued to be observed during identified times and documentation did not indicated that the additional identified interventions were implemented.

Review of the progress notes on an identified date indicated an assessment was completed of an identified intervention and the decision was to continue the identified intervention for an identified period of time and that further follow up with an identified behavioural support team was to follow.

Interviews with PSWs #112, #114, and #116, and RN #113 indicated resident #001 had identified behaviours specifically during an identified time and witnessed resident #001 display identified responsive behaviours towards residents during an identified time. The staff indicated the plan of care provided identified interventions to manage resident #001's identified responsive behaviours but these identified interventions were not very effective as resident #001 would further display identified responsive behaviours toward them. The staff further indicated that there were no procedures and interventions implemented other than what they had mentioned implemented to assist residents and staff who were risk of harm as a

result of resident #001's identified responsive behaviours.

Interview with PSW #135 indicated that when they had been assigned to resident #001 to provide an identified care during an identified time and were directed to provide an identified intervention from the plan of care to avoid resident from displaying further identified responsive behaviours. They indicated the identified intervention was not very effective. PSW #135 further indicated that there were no other procedures or interventions developed to assist and minimize the risk of potentially harmful interactions by resident #001.

Further interviews with PSWs #112, #114, #116, PSW #135 and RN #113, indicated that during an identified time, resident #001 was monitored for an identified time and in an manner and was distracted in an identified manner when the resident would attempt to display an identified responsive behaviour. They indicated they did not initiate any other interventions in the plan of care other than the above mentioned interventions.

Interview with the Administrator indicated that the home had in place the above mentioned interventions to manage resident #001's responsive behaviours and had attempted to put into place other procedures and interventions but were not able to due to the SDM’s refusals to consent in the development and implementation of other procedures and interventions

The home failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

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, (a) procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 9 day of March 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : STELLA NG (507) - (A1)

Inspection No. / No de l'inspection : 2018_642606_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 024766-17, 027953-17, 000175-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Mar 09, 2018;(A1)

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 (Vaughan)
10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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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

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:

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

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

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9 day of March 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : STELLA NG - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Ordre(s) de l’inspecteur

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Service Area Office / Bureau régional de services : Toronto