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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 28, 2018	2018_751649_0012	013741-18	Resident Quality Inspection

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

Long-Term Care Home/Foyer de soins de longue durée

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

JULIEANN HING (649), JOY IERACI (665), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 19, 20, 21, 22, 25, 26, 27, 28, 29, July 3, 4, 5, 6, and 9, 2018.

The following intake was inspected:
Log #006608-18/CIS #2969-000006-18 related to the home's IPAC program

A Written Notification (WN) and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 r. 50. (2) (b) (iv) was identified in this RQI inspection which was conducted concurrently with inspection #2018_524500_0009 (Complaint Inspection Logs #010460 and #012516-18), dated August 27, 2018, and issued in that report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC) - Administrative, Clinical Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), RAI-MDS Coordinator, Office Manager, Personal Support Workers (PSWs), Pay Roll Clerk, Dietary Aide (DA), Residents and Family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed delivery of resident care and services, observed staff to resident interactions, observed infection control practices, observed medication administration and reviewed the licensee's medication incidents, reviewed residents' health records, staff training records, minutes of the Residents' Council, and relevant policies and procedures, and conducted resident and family interviews.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **6 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

During the initial tour of the home on June 19, 2018, the Inspector observed the servery door on an identified home unit leading to the dining room unlocked. An ambulatory resident was observed standing in the dining room area not too far from the unlocked servery door. Upon further observation the lights on the steam table were on. During the observation Dietary Aide (DA) #116 came in through the servery back door and observed the Inspector inside the servery area.

In an interview DA #116 confirmed that the servery door on an identified home unit was unlocked and told the Inspector they had turned the steam table on and left to get cutlery through the servery back door.

In an interview the Clinical Manager confirmed the servery door on an identified home unit should have been locked. [s. 9. (1) 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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the program.

During the Resident Quality Inspeciton (RQI) while conducting a medication observation on July 4, 2018, on and identified home unit, the Inspector observed Registered Nurse (RN) #113 had not performed hand hygiene during different routes of medication administration to resident #018. Further observation during the lunch meal service on July 4, 2018, indicated RN #113 had administered medications to several different residents and had not performed hand hygiene before and after residents' medication administration.

A review of the home's policy titled Medication Administration, policy #04-02-01, revised November 2015, indicated hand hygiene will be performed before and after medication administration.

In an interview RN #113 confirmed they had not practiced hand hygiene before and after medication administration to several residents on July 4, 2018.

In an interview the Clinical Manager acknowledged that the registered nurse should have cleaned their hands in between residents and before and after medication administration. [s. 229. (4)]

2. On July 4, 2018, at 0900 hours, the Inspector observed Registered Practical Nurse (RPN) #121 administered an identified oral medication that had fallen on the floor and broken into pieces to resident #033.

In an interview, RPN #121 indicated resident #033 wanted to take the medication even though the RPN showed the resident it had broken into pieces. When asked if administering medication that had fallen on the floor followed the home's infection prevention and control practices, the RPN indicated it had not.

In an interview, RN #118, stated RPN #121, should have discarded the medication and borrowed another medication from resident #033's unused medication strip pack, and informed pharmacy. The RN indicated that RPN #121 did not follow the home's infection prevention and control program.

In an interview, the infection prevention and control (IPAC) Lead #122, indicated when a medication falls on the floor, it is expected for the registered staff to discard that medication, borrow new medication from the resident's unused medication strip pack and notify pharmacy. The IPAC Lead indicated RPN #121 did not implement the home's infection prevention and control program. [s. 229. (4)]

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 all staff participate in the implementation of the program and that on every shift, the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and are consistent with and complement each other.

Resident #001 triggered for altered skin integrity.

A review of the most recent written plan of care indicated the resident was at high risk for altered skin integrity related to several factors. Further review of the resident's weekly skin assessments completed during an identified period, indicated inconsistencies in the assessments.

In interviews the Clinical Manager and RN #114 acknowledged that there were inconsistencies in the content of the assessment. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #011 triggered from stage one of the RQI.

A review of the home's policy titled physician order policy #RC 05-01-01 dated July 1, 2010, indicated the registered staff will inform the resident/SDM of new medication orders including:
-reason for the new medication or treatment
-risk and benefits of the new medication or treatment
-ask if resident/SDM consents or declines the medication/ treatment.

According to the resident's clinical records, decisions about care were made by the resident's substitute decision maker (SDM).

A review of the resident's physician order indicated to give an identified medication twice daily for a specified period of time and then reassess. The physician order did not indicate that the SDM had consented to the new medication. Further review of the resident's clinical records did not indicate any documentation that consent was obtained from the resident's SDM for the new medication.

In interviews, the Clinical Manager and RPN #115 confirmed that the resident's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care since their consent for the above mentioned medication was not obtained. [s. 6. (5)]

WN #4: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 114, the licensee was required to ensure that the medication management system included written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy regarding physician orders - policy #RC 05-01-01, dated July 1, 2010, which is part of the licensee's medication management system.

During the RQI resident #007 triggered for hospitalization and change in condition.

A review of the resident's clinical record indicated the resident had an identified infection and the physician was contacted and ordered several medications.

A review of the home's policy titled physician order, policy #RC 05-01-01, dated July 1, 2010, directed registered staff as follows when taking telephone orders:
1. When receiving telephone orders, repeat the order back to the physician. Write "telephone order", e.g. T.O. or phone order and the name of the physician.
2. Sign your name and status immediately after written entry. Do not leave a space.
3. Clarify and print physician's name in "Physician's Name – Printed" box. The physician will sign his/her telephone orders on the next visit.

A review of the resident's e-MAR indicated they were started on an identified medication for an identified period of time. The Inspector was unable to locate the written physician order for the prescribed medication. The physician order was not written in the resident's chart according to the above mentioned policy and was transcribed directly to the resident's e-MAR.

The Clinical Manager confirmed that the physician order was not written in the resident's chart when the Inspector was trying to locate it. The clinical Manager told the Inspector that it was an agency staff who had taken the order and confirmed that the physician order was not written in the resident's chart. The clinical Manager acknowledged in an interview that the home's policy had not been followed and stated once a telephone order is received the nurse should document on the physician order sheet in the resident's

chart including the date and times along with the physician name. [s. 8. (1)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) 1, the licensee was required to ensure that the provision of the care set out in the plan of care were documented.

Specifically, staff did not comply with the licensee's policy specifically documentation of the resident's assessment - policy # 04-02-01, implemented August 2010, and revised November 2015, which is part of the licensee's documentation policy.

During the RQI resident #007 triggered for hospitalization and change in condition.

A review of the resident's clinical record indicated the resident had an identified infection and the physician was contacted and ordered several medications.

A review of the home's policy titled Medication Administration, policy # 04-02-01, implemented August 2010, and revised November 2015, directed the registered staff as follows under medication administration:
-A resident assessment is to be taken and recorded for an identified time after the initial dose and PRN thereafter at the discretion of the registered nursing staff.

A review of the resident's e-MAR indicated they were started on an identified medication for an identified period of time. Further review indicated the resident's assessment was not recorded on an identified date.

The registered staff who worked on an identified date was an agency staff and not available for an interview.

Interview with the clinical Manager acknowledged that the home's policy was not followed as resident #007's assessment was not recorded every shift for the first 72 hours. [s. 8. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral

under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observation during the initial tour of the home on June 19, 2018, and subsequent observation on June 27, 2018, revealed that the home's inspection reports were posted in a locked cabinet across from the reception desk and duplicate copies kept in a binder at the reception desk. There was signage posted on the locked cabinet indicating copies were available at the reception desk. The duplicate copies of the inspection reports stored in a binder at the reception desk, had to be requested and were not easily accessible.

In an interview the Administrator told the Inspector that the nurse designate can open the locked cabinet at any time. After hours when there was no staff at the reception desk there was signage posted with an identified extension to call or go to an identified unit for assistance.

Based on observations and interviews with the Administrator the inspection reports were not easily accessible as required in the regulation. [s. 79. (1)]

2. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observation during the initial tour of the home on June 19, 2018, and subsequent observation on June 27, 2018, revealed that the home's previous RQI inspection report #2017_420643_0019 was not posted in the locked cabinet or in the binder at the reception desk.

In an interview the Administrator confirmed that inspection report #2017_420643_0019 was not posted in the locked cabinet or a copy in the binder kept at the reception desk. [s. 79. (3) (k)]

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): An outbreak of a reportable disease of communicable disease as defined in the Health Protection and Promotion Act.

The Ministry of Health and Long-Term Care (MOHLTC) received a critical incident system (CIS) report for a disease outbreak in the home.

A review of the CIS report and the home's disease outbreak package indicated the home had an identified outbreak and was declared over by Public Health on an identified date.

Interview with the Administrator of the home indicated that disease outbreaks are to be reported to the MOHLTC immediately. When asked why the disease outbreak the home had during an identified period was reported to the MOHLTC late, the Administrator indicated that the previous Director of Care (DOC) initiated the critical incident (CI) in the CIS system on but did not realized the form was saved in the CIS system, and had not been submitted to the MOHLTC until a later date. [s. 107. (1) 5.]

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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

Issued on this 28th day of August, 2018

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

Original report signed by the inspector.