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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2019	2019_530726_0003	006697-19, 007237-19	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

REBECCA LEUNG (726)

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): May 10, 13, 14, 15, 16, and 21, 2019, and off site on May 31 and June 3, 2019

The following Complaint intake was inspected during this inspection:
Log #007237-19 related to prevention of abuse

The following Critical Incident System related intake was inspected during this Complaint inspection:
Log #:006697-19 - related to prevention of abuse

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 19 (1) was identified in this inspection and has been issued in Inspection Report 2019_530726_0005, dated June 26, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (Administrative), Behavioural Support of Ontario (BSO) Program Nurse, Food Services Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, family member and substitute decision-maker (SDM).

During the course of the inspection, the inspector reviewed resident's health records and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to a resident to resident physical abuse incident involving resident #001 and resident #002. Review of the CIS report indicated that on the date of incident, a personal support worker (PSW) witnessed an altercation between resident #001 and resident #002, resulted in resident #002 sustaining a fall with physical injury. Physician was notified and resident #002 was sent to the hospital for assessment. The police were contacted regarding this incident.

The MOHLTC also received a complaint from resident #002's SDM (#131) regarding resident #002 sustained a physical injury from an altercation with resident #001. SDM #131 was very concerned about the safety of resident #002 and other residents as resident #001 continued to exhibit the same identified responsive behaviour unsupervised in the unit.

Review of progress notes on file, indicated that resident #002 underwent a specified treatment and returned from the hospital on an identified date. Review of physiotherapist's note for an identified date, indicated that resident #002 sustained a specified physical injury. The resident was referred for procurement of a mobility assistive device. A therapy program was initiated.

Review of progress note for an identified date written by the Behaviour Support of Ontario (BSO) program nurse (#109), indicated that resident #002's family voiced a specified concern to the Director of Care (DOC). The DOC ordered a specific monitoring system for resident #002's room and a replacement system was implemented in the mean time. Review of progress note for an identified date written by BSO program nurse #109, indicated that the specific monitoring system was installed in resident #002's room, and resident #002's family was present and aware of intervention.

Review of resident #002's care plan, indicated a critical incident occurred and interventions implemented including applying a specific monitoring system to resident #002's room.

On an identified date and at two different identified time, the inspector did not observe the

specific monitoring system installed in resident #002's room.

During the interview on an identified date, PSW #101 stated that they checked resident #001 on an identified interval and a specific monitoring system was installed in resident #002's room, but the monitoring system was removed, and they did not know why it was removed.

During the interview on an identified date, resident #002's SDM (#131) stated that the staff had put a monitoring system on resident #002's room, but the monitoring system was taken out completely for an identified period of time, and SDM #131 did not know why it was removed.

During the interview on an identified date, Behavioural Support of Ontario (BSO) program nurse #109 stated they were not aware that the specific monitoring system was removed from resident #002's room and they did not know what had happened.

On an identified date and time, at resident #002's room, the inspector observed the specific monitoring system was installed in resident #002's room but it was not applied or activated. In the interviews, PSW #101 and RPN #112 acknowledged that the specific monitoring system should have been applied and activated at all times.

The staff has failed to ensure that the specific monitoring system was applied to resident #002's room as specified in the plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, 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 :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident #001's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident #002, and other residents.

In an interview, resident #002's SDM (#131) said they witnessed resident #001 continue to exhibit the same identified responsive behaviour unsupervised in the unit after resident #002 returned from the hospital. SDM #131 stated they were concerned with the safety of resident #002 and other residents. SDM #131 also stated that on an identified date, they found the staff sit resident #002 next to resident #001 at the same table in the dining room. SDM #131 insisted that the staff had to move resident #001 to another table.

In an interview, PSW #107 confirmed that resident #002 was sitting with resident #001 at the same table in the dining room on an identified date. PSW #107 stated that they were not informed of any change to resident #002's seating plan in the dining room prior to the identified date and they just continued sitting resident #002 at the same table as per their original seating plan. In an interview, RPN #108 acknowledged that SDM #131 requested the staff not to place resident #002 sitting at the same table with resident #001 in the dining room; however they did not move resident #002 to another table on the identified date as they did not observe any issue between the two residents, although they

confirmed understanding family's concern with the potential risk of altercation between the two residents. RPN #108 stated that they communicated SDM #131's request to the day staff for them to notify the management staff.

In an interview, the food services manager (FSM #110) stated that the administrator told them that resident #002's family was in when resident #001 and resident #002 were sitting at the same table in the dining room. FSM #110 said that they spoke with nursing and moved resident #001 to another table. FSM #110 stated that resident #002 was eating in their room after they returned from the hospital, however, before resident #002 was ready to go back to dining room, nursing should have informed them to make the change to resident #002's seating plan in the dining room.

Review of resident #001's care plan, indicated that a critical incident occurred, and interventions implemented including intensive monitoring and initiation of an identified monitoring tool for a specified period of time. Review of progress note for an identified date, RN #104 indicated that resident #001 was no longer on intensive monitoring. Review of resident #001's care plan and Kardex, indicated that no other specific intervention was implemented after the intensive monitoring was discontinued to direct the staff how to manage the identified responsive behaviours exhibited by resident #001 and to minimize the risk of altercation.

Review of the progress notes documented by the registered staff after the incident occurred, indicated that resident #001 continued to exhibit the identified responsive behaviours repeatedly and the staff had difficulty with managing the resident's identified responsive behaviours sometimes. The registered staff also documented that resident #001 continued to exhibit other identified responsive behaviours towards staff, other residents and a visitor.

Review of progress note for an identified date written by physician #128, indicated that resident #001's SDM (#127) was concerned that resident #001 might present risk to others especially when challenged. The SDM was aware that resident #001 had exhibited the identified responsive behaviours which were very difficult to manage.

In an interview with resident #001's primary PSW (#101), PSW #101 stated that they believed the similar critical incident could occur to other residents as resident #001 was still exhibiting the same identified responsive behaviours. PSW #101 stated they checked resident #001 on a specified interval, but they did not know what resident #001 would do in between the safety checks, and the specific monitoring system did not work as

resident #001 could remove the monitoring system without activating it. PSW #101 further indicated that no direction was given to the staff on how to manage resident #001's identified responsive behaviours.

In an interview, PSW #103 stated that they saw resident #001 exhibit the identified responsive behaviours on an identified period prior. PSW #103 stated that resident #001's plan of care did not provide any direction to guide the PSW what to do when resident #001 exhibited the identified responsive behaviours.

In an interview, RN #104 stated that resident #001 was known to exhibit an identified responsive behaviour to staff. RN #104 stated that they did regular safety rounds on an identified interval as they knew resident #001 would exhibit the identified responsive behaviours during a particular shift, and they could not do the safety rounds at a more frequent interval with the usual staffing.

In an interview, resident #003 stated that they witnessed the critical incident occur to resident #002 and did not feel safe living in the unit any more as resident #001 continued exhibiting the same identified responsive behaviours after the incident occurred, and other residents shared the same feelings with them.

In an interview, resident #004 confirmed witnessing resident #001 exhibiting the identified responsive behaviours in their room on an identified day prior and they were feeling afraid.

In summary, after the critical incident occurred to resident #002, the home has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of resident #001's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident #002, and other residents. [s. 55. (a)]

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 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, to be implemented voluntarily.

Issued on this 4th day of July, 2019

[redacted]

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

Original report signed by the inspector.