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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 15, 2019	2019_631210_0013	012114-19, 012347-19	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

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): June 24, 25, 26, 27, 28, July 2, 3 and 4, 2019.

The following intakes were inspected:
-Complaint Log #012347-19 related to Falls prevention and staffing
-Critical Incident System Log #012114-19 related to Falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Corporate Director of Long Term care, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Personal Support Workers (PSW), Resident Assessment Instrument (RAI) Coordinator, residents, substitute decision makers (SDM) and family members.

During the course of the inspection, the inspector observed the provision of care, staff and resident interactions, reviewed resident health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care set out clear directions to staff and others who provided direct care to resident #015.

A complaint was submitted to Ministry of Long Term Care (MOLTC) by a family member related to resident #015 having a fall on a specified date, which resulted in body injury. The family member had a concern related to the staffing level in the home as well.

A Critical Incident System (CIS) report was submitted to MOLTC about the same incident, that caused an injury to resident #015 for which the resident was taken to hospital and which resulted in a significant change in the resident’s health status.

A review of the home’s incident report indicated resident #015 was at high risk for falls since their admission. On the above mentioned date at night time resident #015’s bed alarm was activated. PSW # 144 found the resident on the floor, lying on their side and complaining of pain in a body area. There was urine on the floor. RN #145 assessed the resident and told PSW #144 and #129 to transfer the resident to the bed with a hoyer lift. The physiotherapist (PT) assessed the resident several hours after the fall and transferred the resident to hospital, where they were diagnosed with a fracture and were operated on. Upon the return to the home, the resident was using a wheelchair for mobility.

A review of resident #015’s clinical record indicated the resident was using a device for mobility at admission. The resident had multiple falls since admission. The most recent falls were withing two weeks before the fall with injury, both in the resident's room, one in the morning before breakfast, and the other one in the bathroom at night.

Review of resident #015’s continence assessment at admission indicated the resident was continent of bladder and bowel with occasional incidents and to be toileted every three to four hours.

A review of the PT assessment after multiple falls indicated they recommended staff to have bladder/bowel routine for resident #015. The resident required one person assist while walking with the device because of weak weight bearing.

A review of resident #015’s previous version of the written plan of care, the continence section indicated the resident was usually continent of bladder - incontinent episodes

once a week or less, and to be toileted every two to three hours. Later the care plan was updated that resident #015’s continence management was containment; staff to check for wetness and to toilet during day shift three times at particular times. The RAI Coordinator and DOC were not able to explain what the care plan meant and how it directed staff to assist resident with toileting.

Interview with PSW #129 indicated resident #015 was usually getting up at night to go to the toilet, and they would remove the dry continent product. PSW #129 indicated they usually found the resident already on the toilet, when they responded to the bed alarm. PSW #129 was not able to explain if the resident was on a toileting routine at night, because they usually assist resident #015 when the bed alarm is activated. PSW #129 indicated on the night of the injury, they did not go to resident #015 to assist with toileting for three hours, until their bed alarm was activated.

According to PSW #129, on the night of the incident, at approximately 0200 hrs PSW #129 responded to the bed alarm and when reached resident #015’s room the resident was already sitting on the toilet with the dry continent product removed. They assisted the resident to the bed, placed a new continent product on the resident and went for break. According to PSW #144, they replaced PSW #129 during break, and one hour later they heard the bed alarm. When they reached to resident #015’s room, the resident was on the floor, beside the bathroom door, and there was urine on the floor. The continent product was removed. RN #145 was informed, and they assessed the resident. The resident was complaining of pain in a body part and was transferred to bed with a hoyer lift. According to the progress notes the resident was monitored for head injury because the fall was not witnessed. RN #145 informed the Substitute Decision Maker (SDM) about the fall. During interview PSW #129 indicated that they did not check the resident hourly for three hours before the incident on the specified date, nor they expressed awareness that they had to approach the resident at certain time intervals for assistance with toileting at night.

Interview with PT #120 indicated resident #015 was at high risk for falls, and very quick to reach from the bed to the bathroom. The PT has seen the resident at times walking without the walker and holding the furniture or walls.

Interview with RAI Coordinator #110 indicated the hourly safety checks task was created in Point of Care (POC) for PSWs to document in flow sheets several days after the above mentioned incident. It should be created in Kardex during the initial creation in the care plan, but it was not until six months later. Interview with PSW #129 indicated they do not

check the written plan of care because in the last year they are busy at night, or short of staff and therefore they do not have time to check the computer.

Interview with RAI Coordinator #110, DOC, PT #120, and RN #113 acknowledged that resident #015’s care plan was not reviewed for toileting routine as per the PT’s recommendation, did not provide clear direction to staff in relation to toileting and continence care, and POC was not triggered for PSW hourly safety checks in order to prevent falls. [s. 6. (1) (c)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management.

A complaint was submitted to MOLTC on June 20, 2019 in regards to resident #015 fall on a specified date, which resulted in injury and that the home has one PSW to 30 residents at night.

A review of resident #015's post fall incident report and the staff schedule indicated that when the incident with injury happened, there was an agency registered nurse (RN) on duty at night, on the particular unit of the resident. According to the clinical record resident #015 had two previous falls within two weeks period before the above mentioned incident, one during day shift and another one at night shift. According to the staffing coordinator #107 and the staff schedule, during the second incident, there was an agency RPN and one out of three PSWs was from agency on the same unit. During the third incident, there was one out of two PSWs from agency.

According to s.74 (2) Long-Term Care Homes Act, 2007, S.O. 2007, CHAPTER 8, "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. 2007, c. 8, s. 74 (2).

A review of the education record for falls prevention and management indicated 20% of regular staff were not provided training in 2018.

According to the home's scheduling record for the last three months approximately 6% of all direct care staff (PSWs and registered nurses) were arranged from agency.

Interview with the Director of Clinical Services and the Corporate Clinical Manager indicated that the agency staff that was arranged to work in the home did not receive any training or education in the mandatory areas of education by the home or by the agency, in particular falls prevention and management. The Administrator acknowledged that 20% of the regular staff (PSWs and registered staff) were not provided training in falls prevention and management in 2018. [s. 221. (1) 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 direct care staff are provided training in falls prevention and management, to be implemented voluntarily.

Issued on this 15th day of July, 2019

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

Original report signed by the inspector.