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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## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 08, 2019 | 2018_751649_0022 (A1) | 006654-18, 018461-18 | 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

Amended by JULIEANN HING (649) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

**Ministry of Health and Long-Term Care**

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**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***

**This report has been amended to revoke voluntary plan of correction (VPC) that was issued under s. 3. (1) 14.**

**Issued on this 8 th day of April, 2019 (A1)**

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

**Original report signed by the inspector.**

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

# Inspection Report under *the Long-Term Care Homes Act, 2007*

# Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*


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

Amended by JULIEANN HING (649) - (A1)

## Amended 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): November 16, 19, 20, 21, 22, 27, 28, 29, 30, and December 3, 2018.**

**The following intakes were inspected:**

**Complaint log #006654-18 related to allegation of neglect, short staffing, visitor ban from the home, and privacy breach**

**Complaint log #018461-18 related to allegation of abuse and visitation restrictions**

**This inspection was conducted concurrently with complaint report #2018_751649_0021 for log #025272-17 related to medication management, transferring and positioning, communication methods, abuse and neglect, plan of care, and continence care, follow up order report #2018_751649_0020 related to medication management, and complaint report #2018_462600_0017 for log #021928-17 related to shortage of staff.**

**During the course of the inspection, the inspector(s) spoke with the administrator, director redevelopment and environment services, administrative director of care, nurse designate, registered nurses (RNs), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coordinator, registered practical nurses (RPNs), personal support workers (PSWs), receptionist, maintenance, and family members.**

**During the course of the inspection the inspector observed staff to resident interactions, resident room observations, reviewed resident's health records and reviewed relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Dignity, Choice and Privacy**
**Personal Support Services**

**During the course of the original 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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

(A1)
1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with the Act.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging there had been a breach of privacy related to resident #007.

According to the complaint #111 they were visiting an identified home unit on an identified date when they overheard RPN #122 speaking on the telephone about

resident #007's health condition. According to the complaint they heard the RPN refer to resident #007 using an identified description, heard names of the resident's medications, and other information about the resident's assessment. The complainant provided evidence of the conversation to the inspector.

The inspector reviewed the evidence provided by the complainant and the allegation related to a breach of privacy for resident #007 was confirmed.

A review of resident #007's progress notes on an identified date indicated there was a telephone conversation between RPN #122 and another person.

In an interview with RPN #122 they told the inspector that they may have referred to the resident using an identified description because they were providing a verbal telephone report to someone about resident #007. The RPN stated that an identified description had been used when discussing the resident and that there could have been residents and a family member on the unit at the time of the conversation. RPN #122 acknowledged that there had been a breach of the resident #007's personal health information.

In an interview with Administrator #120, they told the inspector that the physician who had completed the resident's hospital transfer record had written the identified description and the hospital had called the home to inquire about this. According to the Administrator the home did an investigation but was unable to determine who had said the identified term. The Administrator acknowledged there had been a breach in resident #007's personal health information. [s. 3. (1) 11. iv.]

This non-compliance has been revoked. s. 3. (1) 14.

***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 following right of residents are fully respected and promoted: have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with the Act and every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**
**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was received by the MOHLTC related to concerns about the home being short staff especially on the weekends and expressed concerns about the impact on resident #003's care.

A review of the showers and baths documented in point of care (POC) indicated on identified dates resident #003 was not provided a bath, shower or bed bath.

Review of the documentation in POC on identified dates under bed bath it was documented NA. According to the legend at the bottom on the flow sheet NA meant not applicable. Further review of resident #003's progress notes did not

indicate a shower, bath or bed bath had been provided to the resident on the above mentioned dates or thereafter.

In an interview, the RAI-MDS coordinator #112 confirmed to the inspector that NA in the POC documentation meant that the shower was not given.

In an interview, PSW #131 confirmed they had not provided a shower to the resident on an identified date and had documented NA.

In an interview, PSW #115 told the inspector they had not provided a shower to resident #003 on identified date because the unit was short staff.

In an interview, PSW #127 acknowledged they had not provided a shower to resident #003 on an identified date because the unit was short staff and they were working with an agency PSW who was not familiar with the routine and required many things to be explained.

In an interview with receptionist #113 who also assisted with staff replacement and sick calls, the inspector was told that the home was short staff by one PSW staff on an identified home unit on all of the above mentioned dates.

In an interview, the administrative Director of Care #133 acknowledged that showers had not been provided to resident #003 at a minimum of twice weekly on the above mentioned dates. They stated that the expectation was that if the home was short staffed, an alternative arrangement should be made to ensure the resident was provided a shower at the next shift or within the next day. [s. 33. (1)]

**Issued on this 8 th day of April, 2019 (A1)**

[redacted]

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

**Original report signed by the inspector.**