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 |
|---|---|---|---|
| Oct 17, 2019 | 2019_780699_0021 | 011788-19, 012388-19, 012522-19, 016516-19 | Critical Incident System |

## 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

PRAVEENA SITTAMPALAM (699), REBECCA LEUNG (726)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 16, 17, 19, 20, 23, 24, 25, 26, 27, 30 and October 1, 2, and 3, 2019.**

**Off site interviews were conducted on October 4, 7, and 8th, 2019.**

**The following Critical Incident System (CIS) intakes were inspected during this inspection:**

**Log 011788-19, CIS 2969-000027-19, related to staff to resident abuse;**
**Log 012388-19, 016516-19, CIS 2969-000030-19, CIS 2969-000040-19, related to fracture of unknown cause; and**
**Log 012522-19, CIS 2969-000031-19, related to resident to resident abuse.**

**A Voluntary Plan of Correction related to LTCHA,2007, c.8, s. 6 (7), identified in concurrent complaint inspection 2019_780699_0020 (Log #015363-19 and 015884-19) will be issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Environmental Supervisor (ES), Personal Support Workers (PSW), residents and family members.**

**During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, staff training**
**records, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

**6 WN(s)**
**5 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. 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 for resident #011, their responsive behaviour plan of care was provided to the resident as specified in the plan.

The Ministry of Long-term Care (MLTC) received a CIS related to a resident to resident altercation involving resident #011 and #012. Review of the CIS indicated that resident #011 exhibited an identified responsive behaviour towards a staff member at an identified time on a specified date. Resident #011 was seated after exhibiting an identified responsive behaviour however got up and passed by resident #012 and exhibited an identified responsive behaviour towards resident #012. The residents were separated, and resident #011 was sent to hospital. Record review of resident #012's progress notes indicated the resident did not sustain any injuries.

Record review of resident #011's care plan, it indicated the following intervention:
-If resident is exhibiting an identified responsive behaviour, provide barrier between residents to avoid altercations especially if resident has already had an altercation with co-resident, specially resident #012.

In an interview with PSW #142, they indicated that they were the assigned to resident #011 on the day of the incident. They stated that the resident was exhibiting an identified behaviour prior to the altercation. The PSW further indicated that they did not read resident #011's plan of care and was not aware the above mentioned intervention was in place. PSW #142 acknowledged that the plan of care was not followed for resident #011 as they did not provide a barrier between resident #011 and #012.

In an interview with DOC #103, they indicated it was the expectation for staff to read the plan of care prior to performing or giving care. They further indicated that resident #011's plan of care should have been followed. [s. 6. (7)]

2. The licensee has failed to ensure that for resident #013, their plan of care for identified activity of daily living (ADL) was provided to the resident as specified in the plan.

The MLTC received a CIS related to resident #013 sustaining an identified injury. Further review of the CIS did not indicate how the resident sustained the injury. Review of resident #013's progress notes indicated that the resident was observed to have altered skin integrity on an identified date and the cause was unknown.

Record review of resident #013's care plan with full revision history, indicated the following:
- for an identified ADL, the resident required two person total physical assistance; and
- for an identified ADL, the resident required total care with two person.

In an interview with PSW #145, they indicated that at a specified time on an identified day, they assisted resident #013 with specific care. They further indicated that they provided the care to the resident independently. PSW #145 indicated that they were not aware that the resident was a two staff assistance for the identified ADL.

In an interview with DOC #103, they indicated it was the expectation for staff to read the plan of care prior to performing or giving care. DOC #103 acknowledged that for resident #013, their plan of care was not followed. [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.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that PSW #138 complied with the home's written policy and reported suspected neglect of four residents.

The MLTC received a CIS related to staff to resident abuse. Review of the CIS indicated that resident #014, #015 and #016 were found by their PSW to be wearing two briefs and their beds heavily wet on an identified date. The PSW believed that the night PSW did not provide continence care as per residents' plan of care.

Record review of the home's investigation notes indicated that PSW #138 was interviewed regarding the above incident. Review of the PSW's written statement indicated that they had identified four residents in their assignment who were found soaking wet and wearing two briefs on an identified date. The residents identified in their written statement were different from the residents that were identified in the CIS.

In an interview with PSW #138, they indicated that when they came on shift on an identified date, they observed that most of the residents on their assignment were soaked with urine, including bed sheets as well one resident had three briefs on and two others had two briefs on. They further stated that when residents are found soaking wet or if the incontinent product has not been changed, it would be a form of neglect. PSW #138 stated they did not report right away because their other coworker had already reported to management. PSW #138 acknowledged that they should have reported to management immediately.

Record review of the home's policy titled "Zero Tolerance to Resident Abuse and Neglect", policy number RC 01-01-12, it indicates that all staff must immediately report the abuse as per mandatory reporting.

In an interview with Administrator #117, they indicated the staff should have reported the additional residents immediately to management regarding the above incident. [s. 20. (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 the licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the results of an abuse investigation was reported to the Director.

The MLTC received a CIS related to alleged abuse involving resident to resident altercation involving resident #011 and #012.

Record review of the CIS did not indicate the results of the investigation that was conducted by the home. Further review of the home's investigation package did not indicate what the outcome of the home's investigation was.

In an interview with Administrator #117, they indicated that they were aware that the home has ten days to report the results of an investigation to the Director. They indicated the CIS should have been amended with the results of the investigation. [s. 23. (2)]

2. The MLTC received a CIS related to staff to resident abuse. Review of the CIS indicated that resident #014, #015 and #016 were found by their PSW to be wearing two briefs and their beds heavily wet on an identified date. The PSW believed that the night PSW did not provide continence care as per residents' plan of care.

Record review of the CIS did not indicate the results of the investigation that was conducted by the home. Further review of the home's investigation package did not indicate what the outcome of the home's investigation was.

In an interview with Administrator #117, they indicated that they were aware that the home has ten days to report the results of an investigation to the Director. They indicated the CIS should have been amended with the results of the investigation. [s. 23. (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 the licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

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

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**
**1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
**2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
**3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
**4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
**5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
**6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
**7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
**8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
**9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
**10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
**11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that agency PSW received training on the home's abuse and neglect policy.

In an interview with agency PSW #137, they indicated that they did not read or were provided training regarding the home's policy on abuse and neglect.

Record of the home's policy titled " Zero Tolerance to Resident Abuse and Neglect", policy number RC 01-01-12, indicates that the management staff will ensure that all staff and/or contracted individuals, have documented that they have read and understood the policy of Zero Tolerance of Abuse and Neglect. This documentation will be required following initial orientation, annual re-training or other educational events supported by the home.

The inspector was unable to interview the manager at the UMS agency that the home uses for agency staff.

In an interview with Administrator #117, they indicated that the agency is provided education material and the agency would share with their staff. The Administrator stated they were unsure how they would know whether or not the agency staff completed the education and was presently working with the agency to stream line the process. Administrator #117 was unable to provide Inspector #699 confirmation or documentation that agency staff have completed training on the home's policy on abuse and neglect. [s. 76. (2) 3.]

***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 no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home was undertaken promptly after the licensee became aware of it.

The MLTC received a CIS related to staff to resident abuse. Review of the CIS indicated that resident #014, #015 and #016 were found by their PSW to be wearing two briefs and their beds heavily wet on an identified date. The PSW believed that the night PSW did not provide continence care as per residents' plan of care.

Record review of the CIS report, under analysis and follow up, indicated that care was provided to residents as indicated previously and that the staff was not allowed to return to the home. Further review of the CIS report indicated that they would update the CIS with long-term actions to correct the situation and prevent reoccurrence upon completion of the investigation. The CIS was not amended upon review of the LTC portal.

In an interview with the Administrator, they indicated the analysis of an incident of abuse would be found in the CIS report. They acknowledged that the above incident of abuse was not analyzed. [s. 99. (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 an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :**

1. The licensee has failed to ensure that resident #014, #015, and #016, were protected from neglect.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The MLTC received a CIS related to staff to resident abuse. Review of the CIS indicated that resident #014, #015, and #016, were found by their PSW to be wearing two briefs and their beds heavily wet on identified date. The PSW believed that the night PSW did not provide continence care as per residents' plan of care.

Record review of the home's investigation notes indicated that resident #014, #015, and #016 were found to be wearing two briefs and was soaked with urine. Review of resident #014, #015 and #016's progress notes indicated that there was no altered skin integrity identified to the residents.

a.) Record review of resident #014's plan of care indicated that for a specified type of care, the resident required two staff assistance.

In an interview with PSW #140, who reported the alleged neglect, indicated that they observed resident #014 wearing two briefs and was wet with urine. PSW #140 indicated that wearing two briefs and finding residents soaked with urine was a form of neglect.

In an interview with PSW #139, who worked the night of the alleged incident, stated they did not assist the agency staff with care for resident #014 as resident #014 could be assisted with one person. PSW #139 was not aware that the resident required two person assistance for an identified type of care. They denied that they put two briefs on the resident.

b.) Record review of resident #015's plan of care indicated that for specified type of care, the resident required two staff assistance.

In an interview with PSW #140, they indicated that they observed resident #015 was wet with urine and their bed linens were soaked. PSW #140 indicated finding residents

soaked with urine including their bed linens was a form of neglect.

In an interview with PSW #139, they stated they assisted the agency staff with care for resident #015, however could not recall when they changed the resident. Review of PSW #139's hand written statement that was included in the home's investigation package, the PSW did not list resident #015 as one of the residents they assisted PSW #137 with.

c.) In an interview with PSW #140, they indicated that they observed resident #016 wearing two briefs and was wet with urine. They further indicated that they asked the resident why they were wearing two briefs, and the resident said they did not know they were wearing two briefs. PSW #140 indicated that wearing two briefs and finding residents soaked with urine was a form of neglect.

In an interview with PSW #139, they stated they assisted the agency night PSW with changing resident #016 at 2400 and again at 0500. They denied that they put two briefs on the resident.

In an interview with agency PSW #137, who worked the night of the alleged incident and was assigned as the primary PSW for all three residents, stated they arrived to the unit at a specified time. They were told by the home's PSW which resident rooms to go into to provide care. They were not provided with care plans, and access to the PointClickCare (PCC). PSW #137 denied placing two briefs on any residents. Review of the home's investigation notes indicated that the agency PSW admitted to not providing care to two or three residents as they did not have time and assistance. The agency PSW #137 was unable to identify which residents were not provided care. PSW #137 further indicated that they were not trained on the home's abuse and neglect policy. Review of CIS indicated that PSW #137 was no longer allowed to return to the home.

In an interview with Administrator #117, they acknowledged that if a resident was found with double briefs and was heavily wet, that would be considered neglect.

The licensee has failed to ensure that resident #014, #015, and #016, were protected from neglect. Through record review, and staff interviews, two residents were found to be soaked with urine and wearing two briefs and one resident was found heavily wet with urine including their bed linens. The agency PSW #137 was not aware of the specific care needs required by the residents and was not trained on the home's abuse and neglect policy.

This finding is additional evidence for an existing order issued under inspection number 2019_530726_0005, on August 8, 2019, with compliance due date of September 10, 2019. The follow up inspection 2019_780699_020 to this order was completed and complied concurrently with this inspection. [s. 19. (1)]

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**Issued on this 24th day of October, 2019**

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

**Original report signed by the inspector.**