Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 4, 2020	2019_766500_0031	018935-19, 020672-19, 001372-20	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

NITAL SHETH (500)

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 20, 21, 22, 25, 26, 28, December 2, 9, 10, 11, 13, 2019, January 27, 2020 (off-site).

Log #020672-19 related to a complaint about the home restricting family visits, log #018935-19 (CIS #2969-000047-19) related to an alleged incident of neglect from a visitor to the resident and #001372-20 related to pain management were inspected concurrently during this inspection.

The non-compliance identified during this inspection under s.6 (7) and r. 221 (1) for resident #001 is issued in inspection #2019_766500_0032 which was completed concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Corporate Clinical Manager, Registered Nursing Staff, Personal Support Worker (PSW), receptionist, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector observed resident care areas, common areas for family visits, reviewed resident's records and the home's records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that sets out clear directions to staff and others who provided direct care to the resident about providing care to the resident during family visits.

A review of the complaint received by the Ministry of Long-term care (MLTC) indicated that resident #001 had a visit from a family member on an identified day. The home had subsequently restricted the family member from visiting again for a specified period of time, informing that the family member had neglected the resident and put them at risk during their last visit.

A review of Critical Incident System (CIS) report indicated information about an incident related to alleged visitor to resident #001 neglect that resulted in risk of harm to the resident.

A review of the resident's plan of care indicated that the above-mentioned family member who is not the Substitute Decision Maker (SDM), has scheduled visits with resident #001 in a specified location in the home.

A review of the resident's written plan of care indicated that the resident required identified care at certain time intervals. The care plan did not identify direction for staff

about how to manage the resident’s identified care during the above mentioned family visits.

An interviews with Personal Support Worker (PSW) #108 indicated that they do not go to assist the resident until the family member calls them. PSW #108 indicated that they were not sure about implementing the resident’s care plan during family visits.

Interview with PSW #109 and PSW #110 indicated that usually registered nursing staff will do the identified care for the resident during family visits.

An interview with Agency Registered Practical Nurse (RPN) #107 indicated that staff need to complete the identified care for the resident at certain time intervals during family visits, as the identified family member is not the SDM and staff are responsible to implement the plan of care for the resident.

Interview with RPN #113, confirmed that the resident’s care plan does not indicate how staff should provide care to the resident during family visits.

Interview with receptionist #104 indicated that they had never seen PSWs going in the specified location during family visits.

Interview with the Administrator confirmed that the resident’s plan of care should have direction about staff to provide identified care to the resident during family visits.

This non-compliance was issued as the written plan of care for resident #001 did not set out clear directions to staff about providing care to the resident during family visits. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

- A review of resident #001’s written plan of care indicated that the resident had an identified responsive behaviour. Staff to acknowledge the resident's expressions in one on one interactions. Redirect resident to the specified room, give medication as per orders, offer activities of which resident has shown interest and provide one on one session with resident via volunteer/activation staff.

A review of resident #001’s Electronic Medication Administration Record (E-MAR) indicated that the resident was administered a medication as needed (PRN) dose at an identified hour. A review of a progress note indicated that the above mentioned medication was not effective.

- A review of an audio clip provided by the complainant indicated that resident #001 continuously exhibited the identified responsive behaviour during their visit on the identified day. The audio clip indicated that the RPN called the doctor and administered a medication as per the order from the doctor. A review of resident #001’s E-MAR indicated that the resident was administered medication during the above mentioned family visit. A review of a progress note indicated that the medication was not effective.

Interview with RPN #122 indicated that they are required to monitor the effectiveness of the PRN medications and if the medications are not effective, they need to try non-pharmacological interventions and if it does not work, they need to call the doctor and the family.

Interview with the Director of Care (DOC) indicated that the staff are required to try other interventions documented in the resident’s plan of care, monitor the resident, ensure the resident’s safety and call the doctor when the PRN medications are not effective.

This non-compliance was issued as a result of staff having failed to reassess and review and revise the resident's plan of care when the resident’s medication was not effective. [s. 6. (10) (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,
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
-the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident #001's pain was not relieved by the initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of a complaint letter received by MLTC indicated that the registered nursing staff did not re-evaluate resident #001's pain and treat with pain medication and the resident was not comfortable on an identified day.

A review of resident #001's written plan of care indicated that staff to monitor signs and symptoms of pain as the resident may not be able to voice pain due to their health condition. Staff to determine the appropriate pain management methods whenever possible. Provide the resident with alternative comfort measures. Staff to contact the physician if showing signs and symptoms of increased pain.

A review of resident #001's E-MAR indicated that the resident was administered pain medication PRN dose with a specified pain scale. A review of a progress note indicated that the resident's pain scale was increased and the above mentioned pain medication was ineffective. A pain assessment was required as there was a change in the pain scale.

Interview with RPN #122 indicated that they are required to monitor the effectiveness of the PRN medications and if the medications are not effective, they need to try non-pharmacological interventions and if it does not work, they need to call the doctor and family.

A review of the home's policy #02-04-01, entitled, "Pain Management", revised June

2018, indicated that Registered Nursing staff to conduct the pain assessment utilizing a clinically appropriate instrument for Pain Assessment for the resident when pain is not relieved by initial interventions. Implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions (e.g. positioning, distraction, relaxation, massage, aroma therapies, heat and cold). Registered Nursing staff to document in the E-MAR of pain effectiveness and follow up progress note documentation after pain medication provided. If the interventions have not been effective in managing pain, initiate alternative approaches and update as necessary. Registered Nursing staff to consider referral to symptom management consultant for pain that is not controlled. Policy indicated to document the effectiveness of the interventions and evaluate the resident’s response to pain.

Interview with the DOC indicated that the staff are required to try other interventions documented in the resident’s plan of care, monitor the resident, ensure the resident’s safety and call the doctor when the PRN medications are not effective. The DOC confirmed that if the pain medication is not effective, the pain assessment should have been completed in point click care.

This non-compliance was issued as a result of the registered staff failed to complete a pain assessment when the initial intervention was not effective. [s. 52. (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 when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 14th day of February, 2020

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

Original report signed by the inspector.