Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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5700, rue Yonge 5e étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 6, 2022	2021_840726_0001	009323-21, 010486-21, 014592-21, 018995-21	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

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): November 19, 23-26, 29-30, December 1, 2021, and off-site on December 2, 6-7, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #014592-21, CIS #2969-000036-21, related to medication administration;
Log #010486-21, CIS #2969-000026-21, related to prevention of hypoglycemia;
Log #018995-21, CIS #2969-000041-21, related to prevention of hypoglycemia and;
Log #009323-21, Follow-up to Compliance Order (CO) #001 related to medication administration from inspection #2021_714673_0005.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator (AA), Acting Director of Care (ADOC), Resident Assessment Instrument (RAI) Co-ordinator, Physicians, Clinical Consultant Pharmacist, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector reviewed residents' health records, staff training record, investigation notes, medication incident reports, relevant policies, meeting minutes, compliance plan, audit report; conducted observations of residents, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #003 in accordance with the directions for use specified by the prescriber.

A critical incident report was submitted to the Ministry of Long-Term Care (MLTC) related to a registered staff did not administer a medication to resident #003 in accordance with the directions for use specified by the physician.

The registered staff realized the error immediately and notified the charge nurse. They took immediate action to alleviate the impact to resident #003 and obtained additional directions from the physician. Resident #003 reported some pain and symptoms which resolved within 24 hours.

The registered staff acknowledged that they did not administer the medication in accordance with the directions specified by the physician. This was also acknowledged by the Acting Administrator.

Sources: critical incident report, medication incident report, resident #003's clinical records, home's related policy, and interviews with the registered staff and the Acting Administrator. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care related to prevention of hypoglycemia provided clear directions to a registered staff and a PSW.

A critical incident report was submitted to the MLTC related to a severe hypoglycemic incident. The resident involved was admitted with poor glycemic control and received both short-acting and long-acting insulins. They had two hypoglycemic incidents within the first month after admission. They required assistance for feeding and had been eating in their room.

On the date of incident, the registered staff gave the resident the short-acting insulin as scheduled without checking the resident's blood sugar (BS) and did not communicate with the PSW prior. The PSW went to the resident's room with the meal tray about 1.5 hours after the insulin was given and found the resident unresponsive. The registered staff checked the resident's BS which was critically low, and an intervention was administered. The resident became responsive after and their BS improved. The resident was then transferred to the hospital for assessment.

The PSW stated that they were not aware that the resident needed to be fed within 30 minutes after receiving short-acting insulin. The resident's care plan indicated that there was no intervention for prevention of hypoglycemia prior to the incident. The registered staff and the ADOC acknowledged that the interventions should have been included in the resident's care plan.

The physician stated that they were not aware that the short-acting insulin was scheduled before the BS monitoring for the resident prior to the incident. The physician stated that registered staff should check the resident's BS before giving insulin to decide whether they should give insulin to the resident or not.

The pharmacist stated that short-acting insulin was typically scheduled to be given 30 min before meal. The registered staff needed to make sure that the resident ate within 30 minutes to prevent hypoglycemia. The pharmacy system scheduled BS monitoring at mealtimes. The pharmacist acknowledged that BS monitoring should have been scheduled before the administration of short-acting insulin for the resident prior to the incident, and they had already started to review the issue with their management team.

The ADOC acknowledged the scheduling issue and the lack of collaboration between the registered staff and the PSW.

Sources: interviews with the PSW and registered staff, physician, pharmacist and ADOC; resident's clinical records, critical incident report, and home's investigation notes. [s. 6. (1) (c)]

2. The licensee has failed to ensure that a registered staff documented two hypoglycemic incidents for a resident including the provision of care, outcomes and effectiveness of the care provided.

Review of the home's related policy indicated that if a person has a BS level of 4.0 mmol/L or less, they are considered hypoglycemic. If the resident's BS is less than 4.0 mmol/L, the staff needs to assess the resident's condition and take appropriate actions as specified in the policy, based on the resident's level of consciousness to reverse the hypoglycemia.

On two specified dates, the registered staff documented the resident's BS was at a level that was below 4.0 mmol/L. No other documentation was found related to these two hypoglycemic incidents including the interventions provided, outcomes and effectiveness of the interventions.

The registered staff stated that any BS below 4.0 mmol/L would be considered low and they would usually give the resident orange juice with sugar for the low BS. The

registered nurse acknowledged that they should have documented the hypoglycemic incidents for the resident including the interventions provided, outcomes and effectiveness of the interventions. This was also acknowledged by the ADOC.

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 a) 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; and b) the following are documented: the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care, and the effectiveness of the plan of care, to be implemented voluntarily.

Issued on this 12th day of January, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	REBECCA LEUNG (726)
Inspection No. / No de l’inspection :	2021_840726_0001
Log No. / No de registre :	009323-21, 010486-21, 014592-21, 018995-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 6, 2022
Licensee / Titulaire de permis :	Villa Colombo Seniors Centre (Vaughan) Inc. 10443 Highway 27, Kleinburg, Vaughan, ON, L0J-1C0
LTC Home / Foyer de SLD :	Villa Colombo Seniors Centre (Vaughan) 10443 Highway 27, Kleinburg, Vaughan, ON, L0J-1C0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Rachel Muise

To Villa Colombo Seniors Centre (Vaughan) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_714673_0005, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131 (2) of O. Reg. 79/10.

Specifically, the licensee must ensure that medications for resident #003 are administered in accordance with the directions specified by the prescriber.

Grounds / Motifs :

1. Compliance order #001 related to O. Reg. 79/10, s. 131. (2) from inspection 2021_714673_0005 issued on June 8, 2021, with a compliance due date of September 6, 2021 is being re-issued as follows:

1. The licensee has failed to ensure that drugs were administered to resident #003 in accordance with the directions for use specified by the prescriber.

A critical incident report was submitted to the Ministry of Long-Term Care (MLTC) related to a registered staff did not administer a medication to resident #003 in accordance with the directions for use specified by the physician.

The registered staff realized the error immediately and notified the charge nurse. They took immediate action to alleviate the impact to resident #003 and obtained additional directions from the physician. Resident #003 reported some pain and symptoms which resolved within 24 hours.

The registered staff acknowledged that they did not administer the medication in accordance with the directions specified by the physician. This was also acknowledged by the Acting Administrator.

Sources: critical incident report, medication incident report, resident #003's clinical records, home's related policy, and interviews with the registered staff and the Acting Administrator.

Severity: There was minimal harm as the resident experienced some pain and symptoms, which resolved within 24 hours.

Scope: The scope of this non-compliance was an isolated case as no other medication administration incident was identified during this inspection.

Compliance History: In the past 36 months, two voluntary plans of correction (VPCs) and one CO which has been complied, were issued to the home related to same subsection of the legislation; and nine other COs were issued to different sections of the legislation, all of which have been complied.
(726)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 18, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rebecca Leung

Service Area Office /
Bureau régional de services : Toronto Service Area Office