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

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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
Dec 24, 2021	2021_937759_0007	008332-21, 009325-21, 010913-21	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

APRIL CHAN (704759), 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): Nov 19, 22-26, 29-30, and Dec 1-2, 2021.

The following intakes were completed in this Complaint Inspection:
Log #008332-21 related to allegations of abuse and medication management;
Log #010913-21 related to skin and wound and;
Log #009325-21 related to Compliance Order (CO) #002 related to prevention of abuse from inspection #2021_714673_0006.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Admissions Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Infection Prevention and Control (IPAC) lead, Physiotherapist (PT), Behaviour Support Nurse, Wound Care Champion, Personal Support Workers (PSW), and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2021_714673_0006	704759

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the registered staff and others involved in the different aspects of care of a resident collaborated with each other in the confirmation of a new medication order from an outside prescriber so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) that a medication prescribed for the resident by a specialist was not initiated for approximately one month.

The resident was seen at an external clinic, and was prescribed a medication for a specific medical condition. This was faxed by the clinic and was received by the fax machine of the long-term care home (LTCH). The medication was not ordered by the home's physician until a month later. The error was discovered upon a follow-up visit to the clinic. Another prescription was sent to the LTCH the same day and confirmed by the home's physician. During the period between visits to the clinic, the resident experienced some health symptoms, but was being monitored by registered staff and attending physician.

The first faxed prescription was filed into the wrong location of the resident's chart as confirmed by the Acting Administrator. It was the responsibility of registered nursing staff to obtain faxed prescriptions from reception. The attending physician was to be consulted by registered staff to approve other health practitioner medication orders. This process was not performed by the registered staff member who received the faxed prescription.

Sources: the LTCH's investigative notes; the home's Medication Ordering policy, clinical records, complainant, interview with registered staff and Acting Administrator. [s. 6. (4) (b)]

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 registered staff and others involved in the different aspects of care of residents collaborate with each other in the confirmation of new medication orders from an outside prescriber so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure a resident, exhibiting altered skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A complaint was submitted to MLTC by a family member of the resident and a Critical Incident System (CIS) report by the home that the resident sustained multiple skin alterations.

The resident was at risk for falls and skin breakdown because of decreased nutritional intake. The resident had a history of falls since admission and used a loaner wheelchair since a specified date.

Approximately eight months later, the resident had multiple skin alterations. The home hired a Wound Program Champion to lead the Wound Care Program, and a referral was sent to them, about the resident’s skin issues. Skin treatment was applied to the resident from the referral date.

The resident had ongoing issues with skin alterations since they were placed in their wheelchair on a specified date. The treatment to protect the skin was not initiated over the eight-months period, despite the resident frequently exhibiting altered skin integrity.

Sources: Review of the resident's clinical record, review of the home’s policy Skin Integrity Program Overview, interviews with the RPN, PSW, Wound Care Champion, PT and other staff, and resident’s family member. [s. 50. (2) (b) (ii)]

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 resident exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

Issued on this 18th day of January, 2022

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

Original report signed by the inspector.