

**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  
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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 11, 2022	2022_937759_0005	006743-21, 013577- 21, 021136-21, 000910-22	Complaint

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**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)

**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): February 23-25, 28, and March 1-4, 2022.**

**The following intakes were completed in this Complaint Inspection:**

**Log #013577-21 related to kitchen operation;  
Log #021136-21 related to food production;  
Log #006743-21 related to skin and wound;  
Log #000910-22 related to Compliance Order (CO) #001 related to medication  
administration from inspection #2021\_840726\_0001.**

**During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nutrition Manager, Housekeeping Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Infection Prevention and Control (IPAC) Director, Wound Care Champion, Diet Aides, Personal Support Workers (PSW), Housekeeping staff, and residents.**

**During the course of the inspection, the inspector observed resident and staff interactions, reviewed clinical health records, relevant policies and procedures, and other documents.**

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

**Accommodation Services - Maintenance  
Dining Observation  
Infection Prevention and Control  
Medication  
Skin and Wound Care**

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

**1 WN(s)  
1 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:**

<b>REQUIREMENT/ EXIGENCE</b>	<b>TYPE OF ACTION/ GENRE DE MESURE</b>	<b>INSPECTION # / DE L'INSPECTION</b>	<b>NO</b>	<b>INSPECTOR ID #/ NO DE L'INSPECTEUR</b>
O.Reg 79/10 s. 131. (2)	CO #001	2021_840726_0001		704759

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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 :**

1. The licensee has failed to ensure that staff and others involved in different aspects of care of a resident collaborated on wound assessment.

A complaint was submitted to the Ministry of Long-Term Care for alleged improper care for the resident leading to worsening of a chronic skin alteration.

The resident had been managed for a chronic skin alteration and was assessed using a clinically appropriate assessment tool.

On a specific date, the resident was assessed to have a change in the condition of the skin alteration, which was not present six days prior on the previous routine assessment. The type of change of skin alteration was considered a change in status as confirmed by the Wound Care Champion. The ADOC indicated that with change of skin alteration status, the charge nurse should have been informed. There was no referral or clinical notes indicating the charge nurse or home's physician were informed about the change in status until the next reassessment three days later.

The resident was assessed on a later date and showed the skin alteration increased in size and was assessed as a higher severity level. The next day, the resident developed symptoms of systemic infection.

Staff failed to collaborate in assessing the resident after change in skin alteration status was found. The home's expectation was that the charge nurse should have been informed as soon as possible.

Sources: the LTCH's investigative notes; review of the resident's clinical records and progress notes, interview with complainant, Wound Care Champion, and ADOC. [s. 6. (4) (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 staff and others involved in different aspects of care of residents collaborate in the wound assessment, to be implemented voluntarily.***

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**Issued on this 24th day of March, 2022**

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

**Original report signed by the inspector.**