Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
northdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: February 10, 2023	
Inspection Number: 2023-1452-0001	
Inspection Type: Critical Incident System	
Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.	
Long Term Care Home and City: Villa Colombo Seniors Centre (Vaughan), Vaughan	
Lead Inspector JulieAnn Hing (649)	**Inspector Digital Signature**
Additional Inspector(s) Inspector #000705 was present during the inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 13, 16, 17, and 18, 2023.

The following intake(s) were inspected:

- Intake: #00009096, Critical Incident (CI) #2969-000038-22 related to Falls prevention and management.
- The following intakes were completed in this inspection: Intake: #00002756, CI# 2969-000029-21, Intake #00003390, CI #2969-000035-21, Intake #00003693, CI #2969-000016-21, Intake #00006180, CI #2969-000033-22, Intake #00006645, CI #2969-000013-22, and Intake #00015772, CI #2969-000048-22 were related to an injury with a significant change in condition.

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a droplet/contact precaution signage was posted at the resident's room entrance.

Rationale and Summary:
On January 13, 2023, the resident's room entrance had a yellow Personal Protective Equipment (PPE) bag on the door, but no precaution signage was posted. While waiting on a Registered Practical Nurse (RPN) to post the droplet/contact precaution signage a nursing student had gone into the resident's room to conduct an assessment on the resident without wearing goggles or face shield.

The resident's clinical records indicated they had recently returned from hospital and was placed on droplet/contact precaution for an identified respiratory infection.

Failure to post droplet/contact precaution signage at resident's room entrance increases the risk of staff entering the resident's room without using appropriate PPE.

Sources: Observation on January 13, 2023, review of the resident's clinical records, interview with RPN and other relevant staff. [649]

COMPLIANCE ORDER CO #001 Plan of care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
(a) Conduct random audits of the resident's identified intervention for a period of three weeks following the service of this order to ensure compliance with its use.

(b) Complete a reassessment on the use of the resident's identified intervention including documentation of this assessment.

(c) Ensure the resident's identified intervention are applied as per their plan of care.

Grounds
The licensee has failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
(i) The resident sustained a fall with injury.

Review of the resident's plan of care indicated the use of an identified intervention was initiated as a fall intervention approximately 18 months ago. Point of Care (POC) documentation indicated that the identified intervention had not been applied when the resident had fallen and sustained an injury.

The resident had four falls prior to the above fall with injury, and documentation indicated that an identified intervention had not been applied on these days. Review of the resident's POC documentation on application of an identified intervention for the period of three months indicated that it was applied 27 out of 92 days. This same pattern on the application of an identified intervention continued until this inspection.

Personal Support Workers (PSWs) interviews indicated that the resident's identified intervention had not been applied as staff were unable to locate it. There was no documentation of this in the resident's progress notes. Further, there was no documentation of a reassessment on the use of the identified intervention since it had been initiated.

On January 16, 2023, the resident was observed without the identified intervention.

A PSW could not recall with certainty if the resident was using the identified intervention when they fell, but acknowledged upon review of their documentation that the identified intervention was not in use.

A Physiotherapist (PT) acknowledged that the resident still required the identified intervention, and advised that new ones had been provided.

Rationale and Summary:
(ii) On January 16, 2023, the resident was observed in bed, and a specific device was not accessible.

The resident's plan of care indicated they should have a specific device accessible in bed.

Staff failure to follow resident's plan of care on use of an identified intervention, and specific device put the resident at risk of injury.

Sources: Observation of the resident on January 16, 2023, with a PSW, Critical Incident System (CIS) report #2969-000038-22, review of the resident's clinical records, interviews with the PT, PSW, and other relevant staff. [649]

This order must be complied with by March 28, 2023

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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