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

Original Public Report

Report Issue Date: May 5, 2023

Inspection Number: 2023-1452-0002

Inspection Type:
Follow up
Critical Incident System

Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.

Long Term Care Home and City: Villa Colombo Seniors Centre (Vaughan), Vaughan

Lead Inspector	**Inspector Digital Signature**
Noreen Frederick (704758)	Noreen Frederick Digitally signed by Noreen Frederick Date: 2023.05.08 10:12:28 -04'00'

Additional Inspector(s)
Ramesh Purushothaman (741150)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18, 19, 20, 21, 24, 25, 26, 27, 28, 2023

The following intake(s) were inspected:

- Intake: #00009108 -[Critical Incident (CI): 2969-000039-22] Episode of severe hypoglycemia
- Intake: #00012685 -[CI: 2969-000041-22] Allegation of Abuse
- Intake: #00019211 -[CI: 2969-000006-23] Unknown etiology fracture
- Intake: #00020690 - [CI: 2969-000008-23] Unwitnessed fall with fracture
- Intake: #00021325 - Follow-up- Falls Prevention and Management

The following intake(s) were completed:

- Intake: #00004706 - [CI: 2969-000018-22] Fall with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order ##002 from Inspection #2023-1452-0001 related to FLTCA, 2021, s. 6 (7) inspected by Noreen Frederick (704758)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
The resident's care plan indicated that they were scheduled to receive a shower on certain days.

Personal Support Worker (PSW) #118 and #120 stated that they did not provide the resident with a shower as scheduled and specified in their care plan and instead they provided the shower opposite of the schedule. Director of Care (DOC) acknowledged that the staff were expected to provide showers as scheduled in the resident's care plan.

Failure to ensure that the resident was provided with a shower as scheduled in their care plan, placed the resident at risk of not having their hygiene needs met.

Sources: resident's care plan, and interviews with PSW #118, #120, and DOC.

[704758]

WRITTEN NOTIFICATION: Restraining by physical devices

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (1)

The licensee has failed to ensure that a resident's restraint was included in the resident's plan of care.

Rationale and Summary
Inspector's observations revealed that a resident had a restraining device and the resident's plan of care had no indication of this restraint. PSW and Registered Practical Nurse (RPN) stated that the resident was unable to open this device and the device had restraining effects on them. The DOC acknowledged that staff were expected to include this restraining device in the resident's plan of care.

Failure to ensure that the resident 's restraining device was included in plan of their care, placed the resident at risk for confinement and potential injury.

Sources: resident's clinical records, and interviews with PSW, RPN, and DOC.

[704758]

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)

The licensee has failed to ensure that an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents was implemented.

O. Reg. 246/22, s. 11 (1) (b) requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

Specifically, staff did not comply with home's hypoglycemia protocol which was included in the licensee's medication management system.

Rationale and Summary
A resident had an episode of severe hypoglycemia and experienced various symptoms associated with severe hypoglycemia.

The Long-Term Care Home's (LTCH) protocol stated, If Capillary Blood Glucose (CBG) is < than 2.8 mmol/L administer Glucagon 1 milligram (mg) Intramuscular (IM).

RPN and Registered Nurse (RN) stated that they did not administer glucagon as per the hypoglycemia protocol. DOC acknowledged that staff were expected to administer glucagon as per home's protocol.

Failing to comply with the LTCH's protocol put a resident at risk for delayed intervention and potential for further medical complications.

Sources: the home's hypoglycemia protocol "Hypoglycemia Protocol-Unconscious-or Unable to swallow", resident's clinical records, and interviews with RPN, RN and DOC.

[704758]