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: Aug 30, 2023	
Inspection Number: 2023-1452-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.	
Long Term Care Home and City: Villa Colombo Seniors Centre (Vaughan), Vaughan	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.08.30 08:29:51 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31 and August 1-4, 8, 2023.

The following Critical Incident (CI) intake(s) were inspected:
- Intake #00089174 was related to a fall of a resident with injury.
- Intake #00092411 was related to sexual abuse.

The following Complaint intake was inspected:
- Intake #00092563 was related to sexual abuse.

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when their care needs changed.

Rationale and Summary:

The home submitted a Critical Incident (CI) report when a resident fell and returned from the hospital with a new diagnosis.

Prior to the critical incident, the resident's written plan of care for transferring and personal care was not revised for several years. The care plan stated the resident was to be provided with assistance by two staff and transferred with a device and provide peri-care.

A staff documented and acknowledged that a resident was provided with one staff assistance when the resident was assisted to the washroom as the resident's functional ability had improved. Director of Care (DOC) #101 acknowledged that the care plan for the resident should have been revised when their care needs changed.

Failure to include new interventions related to resident's current care needs put them at potential risk of not receiving their care according to their needs.

Sources: Resident's clinical records; interviews with staff.

[741674]

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

The licensee has failed to comply with the strategies to manage pain for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management program, at a minimum, provides for strategies to manage pain for residents and must be complied with.

Specifically, staff did not comply with the policy "Pain Management 02-04-01", dated July 11, 2023, which was included in the licensee's Pain Management Program. The Policy directed Registered Nursing Staff (RPN) to implement strategies to effectively manage pharmacological and non-pharmacological interventions.

Rationale and Summary:

A resident had a fall that resulted in an injury. Prior to the fall, the resident began experiencing pain, which was identified by an assessment and documented by a staff. For several hours the resident's pain went untreated.

A staff and DOC both indicated that the pain the resident experienced at this time should have been treated.

Failure to treat a resident pain may have caused the resident prolonged pain and discomfort.

Sources: resident's clinical records; Pain Management Policy, #02-04-01 (revised July 11, 2023); interview with staff.

[741674]

COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2022, s. 24 (1).

Specifically, the licensee must:
1. Review the contents of this compliance order with all nursing department staff in the home.

2. Re-educate all staff related to the home's policy on Prevention of Abuse & Neglect.
3. Document the review and education provided, including the content of the material reviewed, staff attendance, the date training was completed, and the staff member who provided the education.

Grounds
The licensee has failed to ensure that a resident was protected from sexual abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Rationale and Summary:

Prior to the incident, resident #001 and resident #002 were assessed to be cognitively impaired.

Prior to the incident, a staff informed another staff that resident #002 was in resident #001's bedroom and both residents were sitting on the bed face to face with the door closed.

Several hours later, staff members found resident #002 performing a sexual act with resident #001. The staff separated the residents and verified the resident #001 was not able to provide consent to resident #002 based on the assessments completed by the staff. DOC #101 indicated there was substantiated sexual abuse between residents.

Resident #001 was not protected from sexual abuse by resident #002.

Sources: Critical Incident Report; resident #001 and resident #002's clinical records; LTCH investigation notes; Zero Tolerance of Abuse and Neglect (revised Dec 22, 2022); interviews with staff.

[741674]

This order must be complied with by September 29, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance History: CO#002 [LTCHA 2021], s. 19 (1)] under inspection #2021_714673_0006.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.