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**
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# Original Public Report

**Report Issue Date:** January 17, 2024

**Inspection Number:** 2024-1452-0001

**Inspection Type:**
Critical Incident (CI)

**Licensee:** Villa Colombo Seniors Centre (Vaughan) Inc.

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

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Joy Ieraci (665) | Maria Joy Ieraci<br>Digitally signed by Maria Joy Ieraci<br>Date: 2024.01.18 11:14:51 -05'00' |

**Additional Inspector(s)**
Henry Chong (740836)

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4, 5, 8, 9, 10, 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00099428/CI #2969-000039-23 related to nutrition and hydration;
- Intake: #00101390/CI #2969-000045-23 related to a fall with injury;
- Intake: #00104571/CI #2969-000059-23 related to a COVID-19 and Respiratory Outbreaks;
- Intake: #00098422/CI #2969-000037-23 related to resident to resident abuse;

- Intake: #00101930/CI #2969-000046-23 related to neglect of a resident and nutrition and hydration and;
- Intake: #00099646/CI #2969-000040-23 and #00105032/CI #2969-000062-23 both related to neglect of residents.

The following intakes were completed in this inspection:

- Intakes: #00097791/CI #2969-000035-23 and #00103547/CI #2969-000056-23 both related to falls with injury.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
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 (7)**
*Duty of licensee to comply with plan*
*s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.*

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 related to falls.

**Rationale and Summary**

The home submitted a CI related to a fall with injury that resulted in a change in the resident's health status. The resident was at risk for falls and had a fall intervention in their plan of care.

The intervention was not implemented and was verified by a personal support worker (PSW) in an observation.

The resident may not have received immediate assistance if they had fallen when the intervention was not implemented.

**Sources:** Resident observation; review of CI report, the resident's clinical records; and interviews with a PSW and other staff. [665]

## WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 19 (2) (a)**
*Specific duties re cleanliness and repair*
*s. 19 (2) Every licensee of a long-term care home shall ensure that, (a) the home, furnishings and equipment are kept clean and sanitary;*

The licensee has failed to ensure that a resident's bed was kept clean and sanitary.

**Rationale and Summary**

A PSW assisted the resident with care. The home received a complaint that the resident's bed sheets were not clean, and the sheets were not changed.

The PSW stated that the bed sheets should have been changed.

The Director of Clinical Care confirmed that the PSW did not change the unclean bed sheets.

Failure to keep the resident's bed clean resulted in an unhygienic environment.

**Sources:** A resident's clinical records and home's investigation notes; and interviews with a PSW, Director of Clinical Care, and other staff. [740836]

## WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 184 (3)**
*Binding on licensees*
*s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.*

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applied to the long-term care home, the Minister's Directive was complied with.

**1)** The licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when masking

requirements were not followed by a PSW.

**Rationale and Summary**

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, and the Ministry of Health: COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings, Version 11, June 26, 2023, an N95 respirator was required when interacting within two metres of residents in an outbreak area.

A PSW provided nourishment to residents in a confirmed COVID-19 outbreak RHA wearing three surgical masks instead of an N95 mask.

The Infection Prevention and Control (IPAC) Manager indicated that the PSW was required to wear an N95 mask.

Failure to wear an N95 mask in the outbreak area had put the staff and residents at risk of transmission and exposure to COVID-19.

**Sources**: Observation on one RHA; Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and Ministry of Health: COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings, Version 11, June 26, 2023; and interviews with the IPAC Manager and other staff. [665]

**2)** The licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, when the required personal protective equipment (PPE) was not worn by a PSW and a Registered Nurse (RN) when they provided direct care to COVID-19 residents.

**Rationale and Summary**

In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes and the Ministry of Health: COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings, the required PPE when direct care was provided to confirmed COVID-19 cases were a fit-tested, seal-checked N95 respirator, eye protection, gown and gloves.

The PSW repositioned a resident and the RN administered medications to another resident, without wearing the required gown.

The IPAC Manager indicated that the staff were required to wear the gown to prevent transmission of COVID-19.

Failure to wear the required PPE had put the staff and other residents at risk of transmission and exposure to COVID-19.

**Sources:** Observations on one RHA; Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, Ministry of Health: COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings, Version 11, June 26, 2023, and two residents' progress notes; and interviews with a PSW, RN, IPAC Manager and other staff. [665]

**3)** In accordance with the Minister's Directive COVID-19 response measures for long-term care homes, the licensee was required to ensure that the requirements for case and outbreak management, as set out in the Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate

Living Settings for Public Health Units, were followed.

**Rationale and Summary**

In accordance with the Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units, the use of physical barriers was required to create separation between bed spaces between a COVID-19 case and their roommate.

Two residents were confirmed COVID-19 cases and were in shared rooms. The curtains were not drawn between the residents and their roommates. A Registered Practical Nurse (RPN) verified the observations and indicated that the curtains should have been drawn to separate the bed spaces.

The IPAC Manager indicated that the curtains should have been drawn between the bed spaces to manage close contacts of COVID-19 cases.

There was a risk of COVID-19 transmission to the roommates when the home failed to follow the requirements for COVID-19 contact management for residents in shared rooms.

**Sources:** Observations on one RHA; four residents' progress notes, Minister's Directive: COVID-19 response measures for long-term care homes, August 30, 2022, Ministry of Health: COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings, Version 11, June 26, 2023; and interviews with an RPN, IPAC Manager and other staff. [665]

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
*Infection prevention and control program*
*s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).*

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to IPAC.

**1)** The home has failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes, September 2023". Specifically, support for residents to perform hand hygiene prior to receiving meals as required by Additional Requirement 10.4 (h) under the IPAC Standard.

**Rationale and Summary**

A PSW provided a resident with their meal and did not support the resident to perform hand hygiene prior to receiving their meal.

The PSW acknowledged they did not support the resident with hand hygiene as required in the home's hand hygiene program.

The resident was at risk of infection transmission when they were not supported to perform hand hygiene prior to their meal.

**Sources:** Observation on one RHA; IPAC Standard, Revised September 2023, and

interviews with a PSW and other staff.

**2)** The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard". Specifically, hand hygiene including the four moments of hand hygiene, as required by Additional Requirement 9.1 (b) under the IPAC standard.

**Rationale and Summary**

A resident was on additional precautions and a PSW provided direct care to the resident without performing hand hygiene before initial contact and after resident contact.

The PSW acknowledged they were supposed to perform hand hygiene but did not.

There was a risk of infection transmission to residents when the PSW did not perform hand hygiene.

**Sources:** Observation on one RHA, IPAC Standard, revised September 2023, a resident's progress notes; and interviews with a PSW and other staff. [665]