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: April 19, 2024	
Inspection Number: 2024-1452-0002	
Inspection Type: Complaint Critical Incident (CI)	
Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.	
Long Term Care Home and City: Villa Colombo Seniors Centre (Vaughan), Vaughan	
Lead Inspector Joy Ieraci (665)	**Inspector Digital Signature** Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2024.04.19 14:53:02 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 8, 9, 10, 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00106194/CI related to a fall;
- Intake: #00106971/CI related to an allegation of neglect, pain management and physiotherapy services and;
- Intake: #00107459/Complaint, related to foot care and skin and wound management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

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

Rationale and Summary

A resident was assessed to be at risk of a health condition and had a history of the condition. There was a change in the resident's health status, which worsened over a nine-day period. The resident was transferred to hospital and diagnosed with the health condition and another medical concern.

The plan of care directed staff to monitor for signs and symptoms of the health condition during daily interactions with the resident using the home's Clinical Pathway (CP) for the health condition. The CP required that screening for the health

condition was to be completed when there were any new or worsening symptoms/significant change in health status.

The In-Charge Registered Nurse (RN) acknowledged that the resident exhibited signs and symptoms of the health condition and the required screening and assessment were not completed as per the plan of care.

The Director of Care (DOC) acknowledged that the screening and assessment for the health condition were not completed as per the plan of care until after the resident's return from hospital.

Failure to follow the resident's plan of care related to the health condition may have delayed the resident's treatment and transfer to hospital for management of their other medical concern.

Sources: Review of resident's clinical records; and interviews with In-Charge RN, DOC and other staff. [665]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

Altered skin integrity was discovered on a resident. An assessment was completed upon discovery; however, subsequent weekly assessments were not completed. There was no further documentation as to when the altered skin integrity resolved.

The DOC and the Wound Care Nurse acknowledged that weekly assessments were to be completed until the altered skin integrity had resolved and or healed. Both confirmed that weekly assessments were not completed for the resident's altered skin integrity.

Failure to the complete weekly assessments may have impacted the effectiveness of the treatment and healing of the resident's area of altered skin integrity.

Sources: Review of resident's clinical records; and interviews with Wound Care Nurse, DOC and other staff. [665]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record of a verbal complaint regarding the care of a resident was kept in the home.

Rationale and Summary

The DOC acknowledged they received a verbal complaint related to the care of a resident.

The home's Complaints Binder did not have documentation of the verbal complaint.

The DOC confirmed that they did not document the verbal complaint as required.

There was no risk to the resident, however the home's review and analysis of their complaints may not be as effective when determining any improvements required for resident care.

Sources: Review of 2024 Complaints Binder, resident's progress notes; and interview with DOC. [665]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s.

140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident had altered skin integrity and the the physician ordered a medication for a specified number of days, and as-needed/required. The medication was first administered five days after it was ordered; and the as-needed/required order was administered as a scheduled medication five days later as well.

The DOC indicated that the medication orders were processed by the registered staff five days after it was ordered, which caused the missed doses. The as-needed order was entered incorrectly by the registered staff as a scheduled medication instead of an as-needed medication. The DOC confirmed that the resident did not receive the medication as prescribed.

Failure to administer medication as prescribed may have affected the time required for the altered skin integrity to heal and the resident's skin may have been at risk of breakdown when the as-needed ordered was administered as a scheduled medication.

Sources: Review of resident's clinical records; and interviews with DOC and other staff. [665]