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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Public Report

Report Issue Date: January 2, 2025

Inspection Number: 2024-1452-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-6, 9-11, 13, 16-18, 2024

The following intake was inspected in this Complaint inspection:

- Intake: #00131455 - related to resident care and services, dining and snack services, and allegations of neglect

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00128339 [CI: 2969-000101-24] - related to a fall of a resident resulting in an injury
- Intake: #00130459 [CI: 2969-000110-24] - related to a disease outbreak
- Intake: #00131424 [CI: 2969-000122-24] - related to allegations of neglect of a resident
- Intakes: #00125264 [CI: 2969-000091-24], #00131071 [CI: 2969-000118-24], #00131889 [CI: 2969-000129-24] and #00132186 [CI: 2969-000131-24] - related to allegations of improper/incompetent care of a resident

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Pain Management
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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that a Personal Support Worker (PSW) collaborated with the registered nursing staff to ensure a resident's pain was assessed.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint that a resident was in pain and the PSW did not report to the nurse for further actions.

The resident informed the PSW that they were experiencing pain and gestured toward a body part. The resident's clinical records showed there was no documentation from the registered nursing staff about the resident's pain.

The Director of Care (DOC) stated PSWs were expected to report signs of pain to the registered nursing staff. The DOC acknowledged that the PSW did not collaborate with the registered nursing staff and as a result, the resident's pain was not assessed.

Failure to ensure the nursing staff collaborated with each other put the resident at risk of delay in receiving assessment and treatment.

Sources: Video footage, a resident's clinical records; and interview with DOC.

WRITTEN NOTIFICATION: Communication methods

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 47
Communication methods
s. 47. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

The licensee has failed to ensure that communication strategies were implemented to meet the needs of a resident, who communicated in another language.

Rationale and Summary
The MLTC received a complaint from a resident's Substitute Decision-Maker (SDM) that the staff were not using communication strategies when the resident verbalized they needed to use the toilet.

The resident asked to use the toilet in another language, and the PSW was not aware the resident needed to use the toilet. The staff member did not use the communication strategies in the resident's plan of care to communicate with the resident.

The DOC acknowledged the PSW did not use the communication method strategies in the plan of care to communicate with the resident.

Failure to use the communication strategies in the resident's plan of care delayed provision of care for the resident.

Sources: Video footage, resident's clinical records; and interviews with PSW and DOC.

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to ensure that staff complied with the home's policy to assess a resident using a communication and assessment method for residents who were unable to communicate their pain.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the home's pain management program must, at a minimum, provide for

communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, and must be complied with.

Specifically, staff did not comply with the home's policy for pain management, which was included in the licensee's pain management program.

Rationale and Summary
A resident's pain levels in their clinical records demonstrated that staff were utilizing two different pain assessment scales to assess the resident's pain. On two separate occassions, staff assessed the resident's pain using one of the pain assessment scale with results above zero out of 10.

A Registered Practical Nurse (RPN) confirmed that they should have used the other pain assessment scale as resident was unable to communicate their level of pain due to cognitive impairment. DOC indicated that staff were expected to use the other pain assessment scale for the resident as they were unable to communicate their pain.

Failure to ensure that staff utilize the correct pain assessment scale as per the home's policy for pain management for the resident could lead to ineffective assessment of the resident's pain levels.

Sources: Home's policy for pain management; a resident's clinical records; and interviews with RPN and DOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure food was served at a temperature that was both safe and palatable to a resident.

Rationale and Summary
The MLTC received a complaint that a resident was served with a food item that was too hot and the PSW continued to feed the resident that food item.

The resident expressed in another language that the food item was too hot. The PSW was not aware the food item was too hot and continued to provide feeding assistance to the resident. The resident expressed several more times that the temperature of the food item was too hot. The DOC acknowledged the food item would not have been served at a safe and palatable temperature if the resident stated it was too hot.

Failure to ensure that food was served at a safe and palatable temperature put the resident at risk of injury.

Sources: Video footage; and interviews with a PSW and DOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that staff used proper techniques to assist a resident with eating, including safe positioning.

Rationale and Summary
The MLTC received a complaint that a PSW did not use safe positioning when assisting a resident with eating. The resident's plan of care includes safe swallowing strategies from the Speech Language Pathologist (SLP), which included specific positioning when seated for all meals.

A PSW did not position the resident at the specific positioning prior to providing feeding assistance. The PSW and DOC acknowledged the resident was not positioned appropriately for eating.

Failure to ensure that the resident was in a safe position for eating put the resident at risk of aspiration.

Sources: Video footage; a resident's plan of care; and interviews with a PSW and DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 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 that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

The licensee has failed to ensure that additional precautions were followed by staff in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC standard), revised September 2023. Specifically, staff did not select the appropriate Personal Protective Equipment (PPE) as required by additional requirement 9.1 (f) under the IPAC standard.

Rationale and Summary
A PSW was observed entering a resident's room on additional precautions in a Resident Home Area (RHA) with gloves, gown, and a N95 mask donned. The signage posted on the door of a resident's room indicated that they were on additional precautions, and staff were required to don eye protection, gloves, gown and a mask to enter the room.

The IPAC manager confirmed that staff were required to wear eye protection in addition to the gloves, gown and a mask for residents on this specific type of precautions.

Failure to ensure that eye protection was worn when entering a resident's room on this specific type of precautions could increase the risk for infection transmission.

Sources: Observations; additional precautions signage on resident's room; interviews with a PSW and the IPAC manager.

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a verbal complaint made to a staff member at the Long-Term Care Home (LTCH) concerning the care of a resident was provided with a response within 10 business days of the receipt of the complaint.

Rationale and Summary
The MLTC received a complaint from a resident's SDM about an incident that occurred where the resident expressed they were in pain and did not receive any assessment.

Review of the home's complaint log and the resident's progress notes showed there was no documentation of the home providing a response to the resident's SDM within 10 business days of receiving the verbal complaint. The DOC confirmed the home did not provide a response to the SDM within 10 business days. The home provided the SDM with a written response about a month later of the receipt of the complaint.

Failure to ensure a response was provided to a resident's SDM within 10 business days delayed communication and resolving concerns with the resident's care.

Sources: A Critical Incident Report (CIR), home's complaint log, a resident's clinical records; and interview with DOC.

WRITTEN NOTIFICATION: Medication management system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that staff complied with the home's policy to sign the Electronic Medication Administration Record (eMAR) when they administered a medication to a resident.

In accordance with O. Reg 246/22, s. 11(1) (b), the licensee was required to ensure that the home's written policies and protocols were developed for the medication management system to ensure the accurate administration of drugs used in the home, and was complied with.

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

Rationale and Summary

A resident received an order for a medication with directions to apply it on every dressing change of an area of altered skin integrity. Review of resident's clinical records indicated that a dressing change was done for the resident's altered skin integrity on four separate occasions after the receipt of the order. However, a review of the resident's eMAR indicated that there was no documentation for the administration of the medication on these specified dates.

Three RPNs indicated that they were unable to recall if they administered the medication as ordered but were aware of the resident's treatment orders for their altered skin integrity. DOC confirmed that staff were expected to sign the resident's eMAR for every administration of the medication.

Failure to ensure that staff signed the resident's eMAR as per the home's policy and protocols could lead to the home's inability to monitor the administration of the medication and efficacy of the treatment.

Sources: Home's policy for medication administration; a resident's clinical records; interviews with three RPNs, and DOC.

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