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:** October 29, 2024

**Inspection Number:** 2024-1452-0004

**Inspection Type:**
Complaint
Critical Incident
Follow up

**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): October 1-4, 7-10, 15, 16, 2024
The inspection occurred offsite on the following date(s): October 11, 2024

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00118563 [CI: 2969-000052-24] - Staff to resident physical abuse
- Intake: #00118909 [CI: 2969-000057-24] - Staff to resident neglect
- Intake: #00119037 [CI: 2969-000060-24] and intake: #00119985 [CI-2969-000064-24] - Improper care
- Intake: #00123911 [CI: 2969-000084-24] - Medication management
- Intake: #00124741 [CI: 2969-000086-24] and intake: #00125120 [CI: 2969-000089-24] - Staff to resident abuse and neglect

The following complaint intake(s) were inspected:

- Intake: #00121355 and intake: #00125670 - Fall prevention and management

- Intake: #00126664 - Neglect, resident care, maintenance and dining services

The following follow-up intake was inspected:

- Intake: #00126007 - Skin and wound prevention and management

The following intake(s) were completed in this inspection:

- Intake: #00119728 [CI: 2969-000063-24] and intake: #00124830 [CI: 2969-000087-24] - Fall prevention and management
- Intake: #00120540 [CI: 2969-000069-24] - Medication management
- Intake: #00125625 [CI: 2969-000094-24] and intake: #00126538 [CI: 2969-000096-24] - Staff to resident neglect, improper care, and fall prevention and management

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1452-0003 related to O. Reg. 246/22, s. 55 (2) (b) (iv).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

# 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)**
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 the resident as specified in the plan.

**Rationale and Summary**
A resident was at risk of falls and had a history of falls since admission. Review of the care plan directed staff to provide a fall intervention for safety.

On an identified date, it was observed that a Personal Support Worker (PSW) and Registered Practical Nurse (RPN) assisted the resident to the washroom. During this time, both staff members did not provide the intervention as directed by the care plan.

The PSW, RPN, Physiotherapist (PT) and Director of Care (DOC) advised that the resident was at risk of falls, and acknowledged that the intervention was not provided as per the care plan.

Failure to follow the resident's plan of care and provide the fall intervention put the resident at risk of falls.

**Sources:** Review of the resident's care plan and other clinical records; observation; and interviews with a PSW, RPN, PT and DOC.

## WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from abuse by staff.

Section 2 of Ontario Regulation 246/22 defines verbal abuse as, "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

**Rationale and Summary**
A critical incident was filed for verbal abuse of a resident by a staff. Review of the critical incident and home's investigation notes identified that there was verbal altercation between a staff and the resident. The staff screamed and swore at the resident. This was witnessed by others.

Another staff, who witnessed the incident and the DOC, acknowledged that the resident was verbally abused by a staff.

Failure to protect the resident from verbal abuse by a staff poses risk to their emotional well-being and caused the resident to become upset.

**Sources:** Review of critical incident #2969-000086-24; home's investigation notes; resident's clinical records; and interview with staff and DOC.

## WRITTEN NOTIFICATION: Reporting certain matters to director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report an incident that resulted in verbal abuse of a resident to the Director.

**Rationale and Summary**
A critical incident was submitted for verbal abuse of a resident by a staff. Review of the critical incident noted that there was verbal altercation between a staff and the resident. The staff screamed and swore at the resident. This was witnessed by others. This incident was brought to management's attention several weeks later.

Another staff who witnessed the incident and the DOC, acknowledged that the resident was verbally abused by a staff; and the abuse should have been reported immediately.

Failure to ensure the incident of staff to resident abuse was immediately reported, created a missed opportunity for the home to take appropriate action.

**Sources:** Review of critical incident #2969-000086-24; resident's clinical records; and interviews with staff and DOC.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 40**
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident after a fall.

**Rationale and Summary**
Review of the Falls prevention and management program policy, titled "Falls - Resident (LTC)" with policy last revised on July 2024, required staff to utilize a specific device after a fall.

On an identified date, a resident sustained a fall. Review of the video footage and

investigation notes by the home revealed that the resident was transferred back to bed without the specific device.

The PT and DOC both acknowledged that after the resident's fall, safe transferring technique was not utilized by the staff when assisting the resident.

Failure to use safe transferring technique after the resident's fall poses risk of injury.

**Sources:** Review of falls prevention and management program policy titled "Falls - Resident (LTC)" with policy #16212555, last reviewed in July 2024; home's investigation notes, progress notes and other clinical records of the resident, and video footage for fall; and interviews with PT, DOC, and other staff.

## WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee was required to ensure that, after a fall, the resident was not moved prior to completion of

preliminary assessment by registered nursing staff, and must be complied with.

Specifically, staff did not comply with falls prevention and management policy titled "Falls - Resident (LTC)," after a resident fell.

**Rationale and Summary**
On an identified date, a resident sustained a fall. Review of the video footage and investigation notes by the home revealed that the resident was transferred without preliminary assessment by the nurse after the fall. Review of the falls prevention and management program policy, titled "Falls - Resident (LTC)," last revised on July 2024, directed the staff to ensure that the resident was not moved prior to completion of preliminary assessment by registered nursing staff, which was not complied with.

The PT, Infection Prevention & Control (IPAC) Manager and DOC acknowledged that the resident was moved prior to completion of preliminary assessment by registered nursing staff and that the falls prevention and management policy was not complied with.

Failure to implement the home's falls prevention and management policy and transfer the resident prior to being assessed poses the risk of worsening the resident's injury.

**Sources:** Review of policy titled "Falls - Resident (LTC)" with policy #16212555, last revised on July 2024; progress notes and other clinical records of the resident, and video footage, home's investigation notes; and interviews with PT, DOC and IPAC Manager.

## WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (1) 2.**
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

The licensee has failed to comply with the home's skin and wound care program to have weekly assessments completed for skin injuries.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to provide strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents and must be complied with.

Specifically, staff did not comply with the policy "Skin Care Program: Assessment and Care Planning, 02-05-04," which was included in the licensee's skin and wound program.

**Rationale and Summary**
A resident's substitute decision maker (SDM) notified the home of altered skin integrity to the resident. Registered staff assessed the resident and identified various areas of altered skin integrity.

The home's policy "Skin Care Program: Assessment and Care Planning, 02-05-04 (last revised 02/2022)" directed residents to be assessed at least weekly by a member of the registered nursing staff using the weekly wound assessment when exhibiting skin breakdown and/or skin injuries. The weekly wound assessments

were not completed for the various skin injuries.

A RPN stated that the skin and wound assessments were not reassessed weekly. The Assistant Director of Care (ADOC) confirmed that staff were expected to complete the weekly skin and wound assessment using the skin and wound evaluation assessment when there were changes of altered skin integrity.

Failure to complete weekly skin and wound assessments for the resident could result in delayed treatment and evaluation of skin injuries progress by staff.

**Sources:** Resident's skin and wound assessments; Skin Care Program: Assessment and Care Planning Policy, 02-05-04 (last revised February 2022); and interviews with a RPN and ADOC.

## WRITTEN NOTIFICATION: Medication management system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)**
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that a RPN implemented the home's medication administration policy when administering medication to a resident.

**Rationale and Summary**
As per a resident's Medication Administration Record (MAR), they were scheduled to receive medications at a specific time. According to home's policy titled "Medication

Administration (LTC)," medication was to be administered as close to the scheduled time as possible within one hour before and after the designated time and to the right client.

On an identified date, a RPN provided another resident's medication to the resident; furthermore, the RPN provided several medications that were not at the scheduled administration time. The resident refused to take the medications.

As per the home's investigation notes, the RPN failed to check the medications against the resident's Electronic Medication Administration Record (eMAR), to complete the five rights of medication administration, to check resident's name on the medication and to give medications on time as per the policy titled "Medication Administration (LTC)."

The RPN confirmed that they did not check the resident's name before providing the medications, and provided several medications scheduled at the incorrect scheduled administration time. A Registered Nurse (RN) and the DOC both confirmed that the RPN did not follow home's policy titled "Medication Administration (LTC)."

Failure to follow home's policy titled "Medication Administration (LTC)" placed the resident at risk of medication error.

**Sources:** Review of a resident Medication Administration Record; home's policy titled "Medication Administration (LTC) - 15837111, last revised on May 2024 and home's investigation notes; and interviews with a RPN, RN and DOC.