Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2013	2013_102116_0065	T-686-13	Other

Licensee/Titulaire de permis

VILLA COLOMBO SENIORS CENTRE (VAUGHAN) INC.
10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0

Long-Term Care Home/Foyer de soins de longue durée

VILLA COLOMBO SENIORS CENTRE
10443 HIGHWAY 27, KLEINBURG, VAUGHAN, ON, L0J-1C0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): December 6, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager (FSM), RAI Coordinator, Programs Manager, Resident Council President, Registered staff and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the health record of a resident, observed staff to resident interactions and lunch meal service.

The following Inspection Protocols were used during this inspection:

Dining Observation
Nutrition and Hydration
Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions for the staff and others who provide direct care to Resident #1 in relation to food allergies.

- The inspector confirmed through a record review that Resident #1's profile, Eating/Swallowing section of the care plan and diet list located in the servery, all identified that the resident has a specified food allergy. The soup of the day was served to Resident #1 at lunch on a specified date. The PSW queried the appropriateness of the soup for Resident #1 related to the Resident's specified food allergy. It was confirmed by a kitchen staff member that the soup was acceptable to serve. The ingredients of the soup were not confirmed. The Registered Staff confirmed the specified food allergy in the plan of care. As a precaution, the soup was removed and replaced with broth. The dietary aide who served the soup originally was aware of the specified food allergy but was unaware the soup contained the allergen. The FSM further confirmed that the soup contained the allergen [s. 6. (1) (c)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions for the staff and others who provide direct care to Resident #1 in relation to food allergies, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

- On a specified date, the inspector observed an unidentified orange and white pill stored in a medication cup in the medication cart on an identified unit. There was no identification of the type of medication and the resident it was prescribed for.
- Interview held with a Registered staff member confirmed that refused medications should be disposed of during the shift they were attempted to be administered on. The Registered staff was unable to identify the type of medication and which resident it was prescribed for [s. 126.].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

Issued on this 18th day of December, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs