

Ministry of Health
and Long-Term Care

Ministère de la Santé
et des Soins de longue durée



Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Toronto Service Area Office

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance
et de la conformité
Bureau régional de services de Toronto

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Toronto ON M4V 2Y7

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JAN 06 2011

Mr. Fernando A. Scopa
Executive Director
Villa Colombo
40 Playfair Avenue
Toronto ON M6B 2P9

Dear Mr. Scopa:

Please find enclosed the **Inspection Report-Public Copy** for an inspection conducted **November 30, December 3, 2010** under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

Telephone: 416-325-9297
1-866-311-8002

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the **Inspection Report-Public Copy** must be made available without charge upon request. The report will also be on file with the Toronto Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

A handwritten signature in cursive script, appearing to read "A. Mancillo".

for Tiina Tralman
LTC Homes Inspector

under the LTCHA
must be posted in the home

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Date(s) of inspection/Date de l'inspection November 30 and December 3, 2010	Inspection No/ d'inspection 2010_162_2969_30Nov095108	Type of Inspection/Genre d'inspection Critical Incident
Licensee/Titulaire Villa Colombo Seniors Centre (Vaughan), Inc 10443 Highway 27, Kleinburg, Vaughan, ON, L0J 1C0 Fax 289-202-2000		
Long-Term Care Home/Foyer de soins de longue durée Villa Colombo di Poce Centre 10443 Highway 27, Kleinburg, Vaughan, ON, L0J 1C0 Fax 289-202-2000		
Name of Inspector(s)/Nom de l'inspecteur(s) Tiina Tralman (162)		
Inspection Summary/Sommaire d'inspection		
The purpose of this visit was to conduct a critical incident inspection. During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Nurse Practitioner/Director of Clinical Services, Registered Nursing Staff, Personal Support Workers, Registered Dietitian, and Food Service Manager. During the course of the inspection, the inspector: Reviewed health record, observed meal service and staff providing care to residents, reviewed menus and education in-services related to feeding practices. The following Inspection Protocols were used in part or in whole during this inspection: Nutrition and Hydration Dining Observation ☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 1 WN		

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the Long Term Care Homes Program Manual Standards and Criteria.

Criteria B2.4: Each resident's plan of care shall reflect his/her current strengths, abilities, preferences, needs, goals, safety/security risks, and decisions including advance directives provided by the resident or any substitute decisions provided by the lawfully authorized person. The plan of care shall give clear directions to staff providing care.

Findings:

An identified resident was reassessed identifying the need for textured food item in response to nutritional risk for problems associated with impaired swallowing and chewing. Furthermore, the interdisciplinary team conference record indicated the need for textured food item. The plan of care did not give clear directions to staff to provide this intervention.

Inspector ID #: 162

Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.

Tiina Tralman



Title:

Date:

Date of Report: (if different from date(s) of inspection).

December 9, 2010