Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 16, 2017	2016_290551_0031	028298-16, 035073-16	Critical Incident System

Licensee/Titulaire de permis

VILLA MARCONI LONG TERM CARE CENTER
1026 BASELINE ROAD OTTAWA ON K2C 0A6

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

VILLA MARCONI
1026 BASELINE ROAD OTTAWA ON K2C 0A6

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

MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 6 and 9, 2016.

Log #028298-16 related to the unexpected death of a resident and log # 035073-16 related to concerns about the care of a resident were inspected.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Dietary Aide, Registered Nursing Staff, the Food Service Supervisor, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed health care records, the Blue - Medical Emergency policy and procedure and the therapeutic menu for a specific day.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's written plan set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident Report was submitted to the Director, under LTCHA, s. 24 on a specified date reporting the unexpected death of resident #001.

Resident #001 was admitted to the home on a specified date and had several medical diagnosis.

According to the written plan of care that was in effect at the time of the resident's passing, resident #001 was on texture modified diet. One section of the care plan, titled eating, specified that the resident required one-person physical assistance with feeding and directed staff to provide the resident with tools to assist with independence such as a straw, plate guard or cutlery with handles. Another section of the care plan, titled eating, directed staff to feed the resident because the resident ate too fast. Another section of the care plan, titled nutritional status, stated that the resident ate best with finger foods.

A review of resident #001's health care record indicated that following episodes of choking on specified dates, the resident was assessed by the Registered Dietitian (RD), and a texture modified diet was ordered. In her assessment, the RD noted that resident #001 required feeding as he/she ate too quickly which increased the resident's risk for choking. The most recent Minimum Data Set (MDS) assessment coded the resident as

requiring total dependence for eating.

On January 6 and 9, 2017, respectively, PSW #102 and #106 stated to the inspector that the resident was on a texture modified diet and sat alone at a table for meals. PSW #106 stated that resident #001 required feeding and monitoring from staff due to his/her tendency to grab food and eat quickly. PSW #102 and RPN #101, who was interviewed on January 6, 2017, stated that resident #001 could feed himself/herself, to promote independence, if staff were supervising. On January 9, 2017, RPN #104 and Dietary Aide #105 stated that on the day shift, the resident sat alone for meals.

RPN #101 stated that if there were extra staff, the resident would sit alone at supper. The RPN, who was working the evening shift on a specified date and who was passing medications in the dining room when the incident happened, stated that at supper on this day, the resident was not seated alone.

A statement written by PSW #108, who was assigned to the area where the resident was seated on a specified date, indicated that the resident had fed himself/herself the entrée, and that she fed him/her a dessert that was consistent with his/her dietary needs. While the resident was seated at the table, after having completed dessert, he/she was found to be in distress. A code blue was called. Statements written by RPN #101 and PSW #109 indicated that the resident had been served the proper texture of food.

RN #107, who responded immediately to the code blue, stated that the paramedics took over when they arrived at the home. The resident's death was pronounced at a specific time. According to the investigating coroner, a preliminary cause of death was specified.

The written plan of care does not provide clear direction as one section directs staff to provide one person physical assistance with feeding and tools to assist with independence, another section directs staff to feed the resident due to eating too fast and choking risk, and another section states that the resident eats well with finger foods. The care plan does not provide clear direction as to the resident's seating requirement or address his/her tendency to grab food from others. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #001's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

According to the written plan of care that was in effect at the time of the resident's passing, resident #001 was on texture modified diet. One section of the care plan, titled

eating, specified that the resident required one-person physical assistance with feeding and directed staff to provide the resident with tools to assist with independence such as a straw, plate guard or cutlery with handles. Another section of the care plan, titled eating, directed staff to feed the resident because the resident ate too fast. Another section of the care plan, titled nutritional status, stated that the resident ate best with finger foods.

On January 6, 2017, PSW #102 and RPN #101 were interviewed and stated that resident #001 could feed himself/herself, to promote independence, if staff were supervising.

RPN #101 stated that if there were extra staff, the resident would sit alone at supper. The RPN, who was working the evening shift on a specified date and who was passing medications in the dining room when the incident happened, stated that at supper on this day, the resident was not seated alone. On January 9, 2017, RPN #104 and Dietary Aide #105 stated that on the day shift, the resident sat alone for meals.

On a specified date, resident #001's SDM told inspector #551 that he/she was under the impression that the resident required complete assistance for feeding and sat alone for all meals. The resident's SDM stated that he/she had not been made aware that the resident had resumed being able to feed himself/herself some of the time as it had been a long time since the resident fed himself/herself, or when the resident began eating at the same table as other residents. According to a report written by the DOC, after the resident's passing on a specified date, the resident's care plan was reviewed with the SDM. The DOC's report states that he had reviewed the care plan with the resident's SDM, and that the resident required feeding assistance but had improved and was eating well independently with supervision.

A statement written by PSW #108, who was assigned to the area where the resident was seated on a specified date, indicated that the resident had fed himself/herself the entrée, and that she fed him/her a dessert that was consistent with his/her dietary needs. Statements written by RPN #101 and PSW #109 indicated that the resident had been served the proper texture of food. [s. 6. (5)]

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 written plan, related to all residents' nutritional care, sets out clear directions to staff and others who provide direct care to the resident, and to ensure that the residents' SDMs are given an opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

Issued on this 3rd day of March, 2017

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

Original report signed by the inspector.