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
May 23, 2017	2017_617148_0015	005950-17	Resident Quality Inspection

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

AMANDA NIXON (148), KATHLEEN SMID (161), RUZICA SUBOTIC-HOWELL (548), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 18-21, 24-28 and May 1, 2017,

This inspection included five critical incidents including three related to alleged resident abuse and two related to an injury to a resident for which the resident was sent to hospital with significant health change.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), Resident Care & Informatic Manager, Recreation Coordinator, Food Service Supervisor, RAI Coordinator, Human Resources, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Restorative Care, Family and Resident Council Presidents, family and residents.

During the course of the inspection, the Inspector(s) observed resident care areas, resident rooms and common areas, a meal service, a medication pass, the provision of care and services to residents, staff to resident interactions and resident to resident interactions. In addition, the Inspector(s) reviewed resident health care records, relevant policies and procedures including those related to the medication management system, skin and wound and restraint programs and Residents' Council and Family Council minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **2 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident Assessment Instrument Minimum Data Set (RAI MDS) defines a stage 1 pressure ulcer as "a persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved".

The plan of care for resident #029 indicates that the resident has impaired mobility, incontinence and is prone to skin breakdown. A review of the last two RAI MDS assessments for resident #029, indicated that the resident had two stage 1 pressure ulcers. The MDS assessments do not specify the location of the stage 1 pressure ulcers. On April 27, 2017, Inspector #178 interviewed the home's RAI Coordinator who indicated that resident #029 goes back and forth between stage 1 and stage 2 pressure ulcers at a specified area of the body.

The plan of care for resident #031 indicates that the resident has impaired mobility, requires assistance for all activities of daily living, and is identified to be at risk for skin deterioration. A review of the last two RAI MDS assessments for resident #031, indicate

that the resident has two stage 1 pressure ulcers, with the location not specified. On April 27, 2017, Inspector #178 interviewed the RAI MDS coordinator who indicated that resident #031 had two stage 1 pressure ulcers, lat a specified area of the body.

A review of the health care records for resident #029 and resident #031, demonstrated there were no assessments of the stage 1 pressure ulcers using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On April 27, 2017, Inspector #178 interviewed RN #131, who is the home's Skin Care Coordinator. RN #131 indicated that staff do not use a wound assessment tool to assess stage 1 pressure ulcers. Once the skin is broken, the staff would use a wound assessment tool in Medecare (the home's electronic documentation system) to assess the wound.

On April 27, 2017, Inspector #178 interviewed the home's ADOC who indicated that it is the home's practice to use Medecare's assessment tool to assess wounds, skin tears, and pressure ulcers in which the skin is open, but not stage 1 pressure ulcers. The ADOC indicated that a stage 1 pressure ulcer is impaired skin integrity, but because the skin is not open, a wound assessment tool would not be used to assess the ulcer. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On a specified date a critical incident report was submitted to the Director describing an incident related to the omission of medication being administered to twelve residents. Inspector #548 reviewed the home's investigation notes and resident health care records specific to this incident.

On a specified date during the night shift, RPN #115 discovered thirty-one sealed medication pouches to be left on the counter in a medication room. As observed by Inspector #548 each pouch identified a resident, name, dosage and time for each medication to be administered. Each medication was prescribed to be administered on the previous morning shift to residents: #029, #034, #041, #042, #043, #044, #045, #046, #047, #048, #049, #050. The Medication Administration Records was reviewed for each resident. It is recorded that medications contained within each seal pouch were administered by RPN #114.

The next day, in the presence of the Administrator, DOC and Resident Care and Informatic Manager, RPN#114 reported she had not administered prescribed medications to residents: #029, #034, #041, #042, #043, #044, #045, #046, #047, #048, #049, #050, although she had recorded doing so.

As indicated above, drugs were not administered to twelve residents in accordance with the directions for use specified by the prescriber.
(Log# 034867-16) [s. 131. (2)]

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 are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for restraints sets out clear directions to staff and others who provided direct care to resident #029.

On April 21, 2017, Inspector #178 observed resident #029 in a wheelchair, with a table top secured to the wheelchair by a belt which locked at the back of the wheelchair. A front latching lap belt was present, but not applied. On April 24, 2017, Inspector #178 again observed resident #029 in the wheelchair with the table top applied and latched at the back of the wheelchair. In addition, the resident also had a front latching seat belt applied.

On April 25, 2017, Inspector #178 observed resident #029 in the wheelchair with the table top applied and latched at the back of the wheelchair. A front latching lap belt was

present, but not applied. The resident indicated the ability to remove the table top, but when the resident attempted to do so, the resident was unable to remove the table top. The table top was restraining the resident, preventing the resident from rising from the wheelchair.

Review of the unit's restraint binder contained resident #029's physician order, which stated: "apply lap belt for safety when in wheelchair. Table top when necessary". No explanation was present explaining what may make the table top necessary. Also present in the restraint binder was a consent, indicating that the resident's substitute decision maker (SDM) had consented verbally to use of a lap belt and table top.

Review of the resident's current plan of care indicated that a rear locking belt restraint is to be used whenever the resident is in the wheelchair. The plan of care does not mention use of a table top restraint in the wheelchair.

On April 26, 2017, Inspector #178 interviewed five PSWs who care for resident #029. PSWs #132, #121, and #120 indicated that the resident uses a table top restraint which locks in back while in the wheelchair, but no lap belt. PSW #123 indicated that she determines what type of restraint the resident needs either from being told by the charge nurse, or by checking the restraint binder. PSWs #123 and #118 both indicated that the resident uses the table top restraint in the wheelchair, and that the lap belt has been used in the past, but they don't believe the resident needs this anymore. PSWs #123 and #118 both indicated that they determine what type of a restraint a resident needs by looking in the restraint binder, which contains the physicians order and consent.

On April 26, 2017, Inspector #178 interviewed the home's Resident Care and Informatic Manager who, after reviewing resident #029's physician orders and care plan, she indicated that as per the physician orders, the resident should have the seat belt on while in the wheelchair and the table top applied when needed. She further indicated that resident #029's plan of care is not clear, as the plan does not contain any information about the use of the table top, and the physician order does not indicate what "when needed" means in regards to the table top. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #027 is provided to the resident as specified in the plan.

On a specified date, a progress note was written that indicated that there were three occasions that day, whereby staff reminded resident #024 to not bring resident #057 to

resident #024's bedroom. The note describes that resident #024 brings resident #057 to the bedroom and closes the door. The plan of care for resident #024 was updated on the same day, to include suspicious behaviour with interventions including monitoring of the resident's whereabouts every hour and to remind the resident to not bring resident's of the opposite sex into the bedroom and to remove such residents found to be in the bedroom of resident #024 and to redirect the residents to a common area to ensure they remain safe.

Four days after the above described progress note, a critical incident report submitted to the Director describes that PSW #124 observed resident #024 and resident #057 to enter the bedroom of resident #024 and close the door. In an interview with PSW #124, it was reported that she did not make any immediate attempt to remove resident #057 from the bedroom, although aware of the plan of care in place. PSW #124 reported that after a few minutes resident #057 exited the room and was visibly upset. The critical incident report further describes that the resident voiced concerns, including that resident #024 had been sexually inappropriate.

The care for resident #024 was not provided as set out in the plan of care, as it relates to resident #024 having female resident's accompany resident #024 to the bedroom. (Log 030639-16) [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #033 is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On April 20, 2017, resident #033 indicated to Inspector #178 that the resident was not receiving a bath twice a week by the method of the resident's choice. Resident #033 indicated to preference to receive a tub bath, but only receives one tub bath every two weeks. Resident #033 indicated that on other days the resident is bathed in bed.

A review of resident #033's plan of care indicated that the resident requires extensive assistance for all activities of daily living and that the resident is to receive bed baths only, and is to receive the bed bath twice a week.

On April 27, 2017, Inspector #178 interviewed PSW #128, who routinely cares for resident #033 during the day. PSW #128 indicated that the resident's plan of care indicates that the resident is to receive a bed bath twice weekly, but PSW #128 provides the resident with a tub bath once a week because she feels the resident needs it. PSW #128 indicated that resident #033's plan of care calls for bed baths and no tub baths because staff found it too difficult to provide a tub bath for the resident, because the resident is heavy and cannot walk. PSW #033 indicated that as a result, management told the staff to provide bed baths twice a week for resident #033.

On April 28, 2017, Inspector #178 interviewed the ADOC, who indicated that resident #033 is to receive bed baths and no tub baths. The ADOC indicated that she believes that the reasons for resident #033's bathing plan include the difficulty in positioning the resident, as three staff are required, and the fact that the shower chair was hurting the resident. The ADOC indicated that Inspector #178 should speak to the home's Restorative Care employee who conducted the assessment of the resident. On April 28, 2017, Inspector #178 interviewed the home's Restorative Care lead, who indicated that resident #033 receives a tub bath only periodically because the home's existing tub chair does not fit the resident properly, which makes it uncomfortable. The Restorative Care lead indicated that the issue is one of comfort, not safety, as resident #033 has good trunk control. The Restorative Care lead indicated that the home has identified other equipment which may accommodate the resident, but due to budget constraints the other equipment has not been purchased to date. [s. 33. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who is incontinent, has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

The most recent MDS assessments, both indicate resident #013 requires assistance with toileting, is incontinent of bladder, with use of incontinence products and on a scheduled toileting plan.

Inspector #148 spoke with PSW staff members #113, #116 and #117. PSW staff indicated that the resident wears pads due to incontinence and is usually found to be slightly wet of urine when changes or toileting is provided. Day shift PSW #113 noted that the resident can sometimes recognize the need to go to the bathroom and will take him/herself. PSW #113 reported that the resident will call for assistance when toileting or peri care is needed. In addition to this, PSW #113 reported the resident is also toileted before and after the meals. Evening shift PSWs #116 and #117, indicated that the resident is confused and not able to toilet him/herself, reporting that the resident does not call for assistance and requires a toileting schedule. The evening staff indicate that they will check the resident for wetness and toilet at the beginning of their shift and then again before and after the supper meal.

The plan of care for resident #113 indicates that the resident requires one person physical assist for toileting, the plan does not include the resident's bladder incontinence. There is no individualized plan of care, as part of the resident's plan of care, to promote and manage bladder continence. [s. 51. (2) (b)]

2. Resident # 029 is known to have multiple health problems and requires assistance with all activities of daily living.

Review of the resident's health record indicated that the resident was incontinent of urine and stool. The resident's current plan of care stated that the resident wears an incontinent brief, and is to be assisted to use the toilet after meals, at bedtime, and upon request.

On April 26, 2017, Inspector #178 interviewed PSWs #118 and #120 who regularly care for the resident on day shift. Both staff members indicated that they routinely assist the resident to use the toilet between 1000 and 1100 hours daily, and change the resident's brief at that time as well. Both PSW #118 and #120 indicated that they do not assist the resident to use the toilet after lunch, except when the resident specifically requests it.

On April 26, 2017, Inspector #178 interviewed PSW #132 who regularly cares for resident #029 during the evening. PSW #132 indicated that she begins her shift at 1500 hours and she assists the resident to use the toilet in the evening between 1600 and 1630 hours, as well as after supper and at bedtime.

On April 26, 2017, Inspector #178 interviewed the home's Assistant Director of Care, who after reviewing resident #029's current care plan, indicated that the resident should be toileted after lunch, as well as after breakfast, supper and at bedtime, and upon request.

Resident #029 did not have the individualized plan of care to promote and manage bowel and bladder continence implemented. [s. 51. (2) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, if the Residents' Council has advised the licensee of concerns or recommendations related to the operation of the home, care or quality of life, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Writer spoke with resident #037, who is the President of the Residents' Council, the Recreation Coordinator/assistant to the council and the home's Administrator. It was determined that at the time of the inspection, responses to concerns and recommendations were provided verbally to the President or to the council at subsequent council meetings; including such items as extension of the rotational menu. On April 28, 2017, the home's Administrator approached Inspector #148 and noted that a process would be developed to ensure written responses are provided to the Residents' Council. [s. 57. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Inspector #148 interviewed the Family Council Co-chair #126 regarding the licensee's satisfaction survey. In discussion, it was determined that the Family Council had not taken part in any satisfaction survey in the past year.

The Inspector spoke with the home's Administrator, who indicated that the corporate family survey was not available and therefore was not implemented last year. [s. 85. (1)]

2. The licensee has failed to ensure that the advice of the Residents' Council is sought out on the development and implementation of the satisfaction survey.

Inspector #148 spoke with resident #037, the Recreational Coordinator and the home's Administrator. It was determined that the home conducted a satisfaction survey of residents in June 2016; a survey provided to the home by Diversicare. Upon further discussion, it could not be demonstrated that the licenses sought the advice of the resident council in the development and implementation of the survey. [s. 85. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

As described by WN #2, a critical incident was reported to the Director describing an incident related to the omission of medication being administered to twelve residents. The licensee reported that all resident's were monitored for possible ill effects.

On April 28, 2017, during an interview with Inspector #548, the Resident Care and Informatic Manager indicated that when there is a medication incident the unit nurse is to document in the progress notes the assessment of the resident post incident. In addition, she explained that those resident's who required an assessment specific to administration of a medication would have been assessed and this would be documented. Furthermore, she indicated that each resident's primary physician had been notified of the incident and would have assessed each resident.

Inspector #548 reviewed the home's investigation notes and resident health care records for resident's: #029, #034, #041, #042, #043, #044, #045, #046, #047, #048, #049, #050, specific to this incident. There was no documentation of the actions taken to assess each resident post incident. The Resident Care and Informatic Manager indicated that from her review of health care records, there was no documentation to support that each resident was assessed post incident.

The licensee has failed to ensure every medication incident involving a resident and every adverse drug reaction is reported to the pharmacy service provider.

On April 28, 2017, during an interview with Inspector #548, Resident Care and Informatic Manager indicated that each medication incident is reported to the pharmacy provider by the Director of Care. As it relates to the incident described above, the Resident Care and Informatic Manager, reported to Inspector #548, that it was after her initial discussion with Inspector #161, that the incident was reported to the pharmacy service provider, specifically on April 26, 2017. [s. 135. (1)]

Issued on this 23rd day of May, 2017

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

Original report signed by the inspector.