Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2020	2020_593573_0012	000772-20, 010065-20, 010692-20, 011609-20	Complaint

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

ANANDRAJ NATARAJAN (573), EMILY BROOKS (732)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 21 to 24, 27 to 31, 2020.

Inspector #573 conducted a concurrent Critical Incident System (CIS) #2020_593573_0013 inspection during this complaint inspection.

The following logs were completed during this inspection:

(i) Complaint Log (s):- #000772-20, 010065-20, 010692-20 and 011609-20 concerns related to the resident care/ services.

(ii) CIS Log (s):- #003354-20 and #013346-20 related to an incident that caused injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOCs), the Registered Physiotherapist, the Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and the resident's family members.

During the course of the inspection, Inspector(s) reviewed resident health care records and the licensee's policies. The Inspector(s) observed residents, resident home areas, infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Skin and Wound Care

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

- **3 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	Légende 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. 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 were administered in accordance with the directions for use specified by the prescriber.

A complaint was made to the Ministry of Long Term -Care (MLTC) alleging that a specified medication, for resident #003, was not administered at the correct time on an identified date.

Inspector reviewed resident #003's medication list for a specified month and noted that the physician ordered an identified medication for resident #003, with specific dose and schedule for the use.

Inspector reviewed the Medication Administration Audit Report for the identified month, for resident #003. It was noted that on a specified date, the identified medication was documented as administered; three hours and twenty-five minutes after the dose was scheduled.

Resident #004 also had another identified medication that was not administered at the correct time. It was noted that on a specified date and time, the identified medication was documented as being administered two hours and fifty-eight minutes after the dose was scheduled.(Log #011609-20) [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 were administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the Substitute Decision-Maker (SDM), if any, and the designate of the resident/ SDM have been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the MLTC regarding the care and services received by resident #002 at the Long Term -Care home (LTCH).

Inspector #573 spoke with resident #002's SDM, who reported that the LTCH failed to provide them an opportunity to participate fully in the development and implementation of resident #002's plan of care related to the bed rails.

A review of the licensee's Bed Rails and Bed Safety policy #NUR-05-05-02, dated June 10, 2020, page 6 of 18, under section Bed rail/s use, bullet #3, heading Decisions to use

or to discontinue the use of a bed rails, indicated that the decision must be made in the context of an individualised resident assessment “BED SYSTEM - BED RAILS” completed by an interdisciplinary team with input from the resident and family or the resident’s legal guardian.

The policy also stated that based on the information gathered in the sleeping environment assessment and the resident bed rail assessment, the team will use that information to formulate a clear comprehensive and documented conclusion as to the risk versus benefits to the resident with respect to bed rail use.

Inspector #573 reviewed resident #002’s progress notes, which indicated that resident #001 had a fall incident. Further, the progress notes indicated that resident #002 might climb over the bed rail and is at potential risk for bed rail entrapment.

A physiotherapy referral was initiated immediately as resident #002 was at potential risk for bed rail entrapment. Review of physiotherapy assessment indicated resident #002 does not require the use of bed rail for mobility and the risks of bed rails outweigh the benefits. On a specified date, DOC #114 informed resident #002’s SDM that the resident bed rails were removed to prevent any possibility of injury to the resident.

Inspector #573 reviewed resident health care records and found no individualised resident #002’s “BED SYSTEM - BED RAILS” assessment and their sleeping environment assessment when the decision was made to discontinue the use of the bed rails. Furthermore, there was no documentation regarding any input from resident #002’s SDM nor the risk versus benefits were discussed with the resident’s SDM with respect to the use of bed rails.

Inspector #573 spoke with DOC #103 and DOC #114, they stated that when the decision was made to discontinue the use of the bed rails, no individualised resident assessment and the sleeping environment assessment were conducted for resident #002 as per their policy. Furthermore, both indicated that they did not seek any input nor discuss the risks versus benefits with resident #002’s SDM in relation to the use or to discontinue the use of the bed rails.

The licensee has failed to ensure that resident #002’s SDM was given an opportunity to participate fully in the development and implementation of resident #002’s plan of care related to the bed rails. (Log #010065-20) [s. 6. (5)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care for resident #003 was documented.

A complaint was made to the MLTC alleging that oral care was not provided to resident #003 on the identified dates.

Resident #003 required total assistance with oral care on day and evening shift. PSW #100, #107, and #109 all told Inspector #732 that they completed oral care for resident #003 on their shifts. Inspector reviewed documentation by PSW staff for two specified months and noted that there was no documentation for oral care for four day shifts and two evening shifts.

A complaint was also made to the MLTC alleging that resident #003 did not receive the proper amount of hydration on the identified dates.

Resident #003's plan of care at the time described that resident #003's was on a specified hydration guideline with a specific schedule.

Inspector #732 interviewed multiple PSW staff on different shifts, and all were aware of resident #003's hydration guidelines. Inspector #732 also observed hydration being provided to resident #003 on various dates at various times. PSW #100 and #107 told Inspector #732 that they are to document the resident's fluid intake on Point of Care.

Inspector reviewed documentation by PSW staff for two specified months and was unable to determine if resident #003 received fluids as indicated in their plan of care as there was no documentation for the resident's hydration for five days on different specified hours.

DOC #103 told Inspector #732 that a blank box with no signature indicated that the staff did not complete their documentation. Therefore, the provision of care set out in resident #003's plan of care surrounding oral care and hydration was not documented. (Log #011609-20) [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response.

In accordance with O.Regulation 79/10, s.110(2), the licensee shall ensure that where there is a physical device in use as a restraint, that staff monitor the resident every hour.

Resident #001's health care record identified that the resident was at high risk for falls and had a history of multiple fall incidents.

Resident #001 was observed sitting in a tilted position in a tilt wheelchair. It was confirmed through staff interviews, physician order and the plan of care that the tilt wheelchair is used for resident #001 as a restraint.

Inspector #573 and RN #112 reviewed the POC documentation for resident #001, for a specified month. Upon review, it was noted that the resident's restraint documentation did not capture the resident's hourly monitoring. Furthermore, the RN confirmed that the hourly monitoring of the resident while restrained was not documented.

A Compliance Order CO #002 in relation to s. 31. (1) restraints and its requirements were issued on June 19, 2020 (A4), with the compliance date on October 31, 2020 (A4), by Inspector #573 in inspection report #2019_683126_0032 (A4). (Log #010692-20) [s. 110. (7) 6.]

Issued on this 3rd day of September, 2020

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

Original report signed by the inspector.