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
Apr 27, 2021	2021_878551_0002	025682-20, 000552-21, 004191-21	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): March 23, 24, 25, 26 and 29, 2021 and April 1, 6, 7, 8 and 9, 2021

Log 025682-20 / Critical Incident System (CIS) 2818-000044-20 was related to an allegation of resident to resident abuse.
Log 000552-21 / CIS 2818-000002-21 was related to an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
Log 004191-21 / CIS 2818-000006-21 was related to the fall of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Housekeeper, COVID-19 Screeners, an Antigen Test Clinic Staff, the Assistant Director of Care and Infection Prevention and Control (IPAC) Lead, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed relevant documents including residents' health care records, and observed the provision of care and services to residents, dining services, COVID-19 screening, antigen testing, housekeeping services and other IPAC measures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plans of care for resident #001 and resident #002 set out clear direction to staff and others who provided direct care to the residents with regards to their physical separation.

An incident of suspected abuse occurred between resident #001 and resident #002. A plan was put in place to keep the residents physically separated.

RPN #102, RPN #106 and RPN #114 stated that resident #001 and resident #002 were to be kept separated at all times.

PSW #112, RN #108 and the DOC stated that resident #001 and resident #002 were to be monitored when they were together and separated as needed.

Resident #001 and resident #002 continued to seek each other out, and both had documented instances of reacting responsively when separation was attempted.

Resident #001 suffered injuries because of a fall that occurred while staff were trying to separate the residents.

The written plans of care for resident #001 and resident #002 did not set out clear

direction to staff and others who provided direct care to the residents with regards to their physical separation.

Sources: CIS 2818-000044-20, CIS 2818-000002-21, resident #001 and resident #002's health care records, interviews with staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plans of care for resident #001 and resident #002 were reviewed and revised when the care set out in the plan was not effective.

An incident of suspected abuse occurred between resident #001 and resident #002. A plan was put in place to keep the residents physically separated.

There were at least ten documented instances of resident #001 and/or resident #002 continuing to seek each other out. There were multiple instances of at least one of the residents reacting responsively when separated or attempted to be separated.

Resident #001 suffered injuries because of a fall that occurred while staff were trying to separate the residents.

The plans of care for resident #001 and resident #002 were not reviewed and revised when resident #001 and resident #002 continued to seek each other out and react responsively to being separated.

Sources: CIS 2818-000044-20, CIS 2818-000002-21, resident #001 and resident #002's health care records and interviews with staff. [s. 6. (10) (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 written plans of care for resident #001 and resident #002 set out clear directions to staff and others who provide direct care to the residents and are reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Three lunch meal services were observed on a home area.

No resident was observed to be assisted to perform hand hygiene before or after any of the three meals.

PSW #115 was observed to escort seven residents, one by one, to the dining room. The PSW did not perform hand hygiene after contact with one resident, and prior to contact with the next, for each of the seven residents. The PSW then poured beverages for residents, and no hand hygiene was performed.

PSW #104 was observed passing soup to residents. The PSW did not perform hand hygiene after delivering soup to one resident, removing the plastic lid which involved contact with the side or lip of the styrofoam container, and moving to the next resident.

Resident #004 who was supposed to be isolated under contact-droplet precautions was observed sitting outside of the dining room. PSW #104 attempted to physically assist the resident from a sitting to a standing position. The resident remained seated, and the PSW walked down the hallway. No hand hygiene was performed after the contact with the resident.

Hand hygiene was not performed in accordance with evidence based practices during the periods of observation.

Sources: "Just Clean Your Hands", the inspector's observations. [s. 229. (9)]

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 hand hygiene is performed by staff and residents in accordance with evidence based practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of any staff members who were present at or discovered the incident.

According to an interview with RN #108, PSW #109 discovered the incident when there was an allegation of resident to resident abuse involving resident #001 and resident #002.

PSW #109 was not included in the report to the Director as a staff who discovered the incident.

Sources: CIR 2818-000044-20 and interviews with RN #108 and PSW #109. [s. 104. (1) 2.]

Issued on this 5th day of May, 2021

[redacted]

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

Original report signed by the inspector.