Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: November 7, 2024
Inspection Number: 2024-1304-0005
Inspection Type: Complaint
Licensee: Villa Marconi Long Term Care Center
Long Term Care Home and City: Villa Marconi, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31, 2024 and November 4-6, 2024.

The following intakes were completed in this complaint inspection:

- Intake: #00128087 related to care concerns of a resident

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Reporting and Complaints
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care - Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

The resident's plan of care had an intervention to assess the resident for any new reddened areas on a pressure point every shift which was incorrectly documented for 14 days in September 2024 by the Personal Support Workers (PSW) staff when the resident had a pressure injury that increased to an infection as a result of failing to provide care as directed in the resident's plan of care.

Sources: Resident's health care records including resident's care plan documentation and interview with RPN Wound Lead and others.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report to the Director a suspicion of abuse of a resident in September 2024 that resulted in harm to the resident.

The resident was found by staff with an injury in September 2024 and the home could not identify the cause of injury. The DOC confirmed that an internal investigation was conducted but no Critical Incident Report (CIR) was submitted to the Director related to the suspected abuse incident.

Sources: Review of CIRs submitted by the home and interview with the DOC.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries,

and provide effective skin and wound care interventions was implemented in the home.

In accordance with Ontario Regulation 246 / 22 s. 11 (1) (b), the licensee is required to ensure the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, as well as provide effective skin and wound care interventions, was complied with.

Specifically, an RPN did not comply with the home's Skin and Wound Management Program when notified that a resident had a pressure injury in September 2024. The Skin and Wound Management Program document "Quality Management" indicates that the RPN was to complete an immediate assessment of the pressure injury, document in the electronic documentation system, send a referral to the dietitian and notify the Wound Lead, and complete weekly assessments among other procedures.

Sources: Review of the home's Skin and Wound Program documentation, resident clinical records, and interviews with an RPN, Wound Lead and the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and

its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that when a verbal complaint was received in September 2024 related to care concerns of a resident, that the complaint response included the Ministry's toll-free telephone number for making complaints and the contact information for the patient ombudsman.

Sources: The Client Service Response form and interview with the DOC.

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The licensee has failed to first receive the approval of the Director prior to commencing renovations to the home.

Specifically, the home did not submit an Operational Plan for approval of the flooring replacement project prior to initiating work in October 2024.

Sources: Observations made on a unit, interviews with Environmental Manager and the Executive Director.

COMPLIANCE ORDER CO #001 Communication and response system

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Immediately conduct a home wide audit of all resident staff communication and response system (RSCRS) pagers in order to:
    1. Determine how many more RSCRS pagers are required to ensure that all PSW's and registered nursing staff carry a pager during their shift, and then order the required number of pagers.
2. Immediately implement a documented operational plan for all nursing staff that do not have access to a functional pager on their shift to ensure that all are made aware of calls for assistance from residents, visitors and other staff without delay.
3. Develop and implement a documented procedure for all nursing staff to follow on every shift that will ensure:
    1. That there are enough pagers for all staff who require one on the unit.

2. That all pagers are tested at the start of the shift, whereby a member of the registered nursing team will activate a call for assistance from a randomly selected location and it will be verified that all pagers are making a sound (in addition to a vibration, if applicable) to alert that staff member to a call.

3. That documented action is taken with regards to any pagers that are not functional, such as a report to the maintenance department or use of a charging system.

4. Develop and implement a written procedure that will ensure that pagers are maintained in a good state of repair at all times, which includes scheduled preventative maintenance for all pagers to occur monthly, at a minimum.

5. Investigate the possibility of reactivating the dome lights above resident bedrooms that will illuminate in response to a call for assistance, in an effort to provide staff with another means of being alerted to calls for assistance. Note that a dome light in the absence of any audible alert would not suffice as a stand-alone method to alert staff to calls for assistance.

6. Implement a documented system, with additional equipment as required, that provides for a system to ensure that registered nursing staff and unit supervisors are alerted by the RSCRS of a call for assistance that has not been responded to within a reasonable amount of time. This procedure can not rely on verbal notification from the PSWs or other staff.

7. Provide documented education for all applicable team members with regards to items 2, 3, 4 and 6 which includes the content, the date training was completed, the individual(s) who provided the education, and the individuals who attended the education.

8. Maintain a written record of everything required under this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the home's resident-staff communication and response system (RSCRS) can be easily seen, accessed, and used by staff in that the RSCRS is not available to all staff that require access to it.

The home's RSCRS is such that staff are only notified of a call for assistance from residents, visitors, or other staff, if they are carrying a functional pager. Based on multiple observations between October - November 2024, there were Personal Support Workers (PSWs) who did not have a functional pager. Issues included that there were not enough pagers available, and that some of the available pagers were not charged. As a result, there was an informal system in place whereby PSWs with a pager would have to verbally notify other PSWs of an active call for assistance. Care unit supervisors, Registered Nurses and Registered Practical Nurses did not have access to pagers and were therefore not alerted by the RSCRS of calls for assistance.

The Environmental Manager and DOC confirmed that there is currently no escalation process so that unit supervisors (RN's and RPN's) are notified when a call bell has alarmed.

There is risk of harm to residents as a result of the current RSCRS as not all staff who require a pager have access to one, and the registered nursing staff and unit supervisors are currently not made aware of calls for assistance from residents, visitors and other staff. If PSW staff are unavailable to answer a call on the unit, there is risk that resident calls can go unnoticed or delayed.

Sources: Observations on all resident units of the RSCRS, interviews with Environmental Manager, the DOC and others.

This order must be complied with by December 23, 2024

COMPLIANCE ORDER CO #002 Skin and wound care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Review the contents of the compliance order with all registered nursing staff and Personal Support Workers (PSW's) in the home areas.
2. Conduct audits once weekly to ensure that registered nursing staff are documenting and assessing in Point Click Care (PCC) appropriately for all residents who are exhibiting altered skin integrity including wounds and pressure injuries and ensure that they are providing immediate treatment, interventions and monitoring as needed to promote resident comfort and mobility and promote the prevention of infection. The audits are to be

completed for a minimum of four weeks, or until all staff are compliant with the process.

3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings including gaps or omissions identified, any corrective actions taken and results of the action.

4. Provide education to all registered nursing staff on the skin care and wound management program, including but not limited to, head to toe and RAI MDS assessments, the electronic wound documentation system, inputting risks and interventions in the resident's plan of care, communicating with the Wound Lead and Registered Dietitian via referral as required, resident pain assessments, and weekly skin and wound evaluations. Include all relevant policies and legislation.

5. Maintain a documented record of education and re-training provided to all registered nursing staff which includes the content, the date training was completed, the individual(s) who provided the education, and the individuals who attended the education.

6. Maintain a written record of everything required under this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that when it was reported that a resident had a pressure injury in September 2024, an RPN did not provide immediate treatment and interventions to prevent infection for the resident.

The resident's foot care nurse notified the RPN of the resident's pressure injury in September 2024. No assessment was completed at that time, and the resident was

not treated for 14 days when the injury became infected. The RPN confirmed that they were notified on a specific date in September 2024 and no immediate treatment or intervention was provided to the resident to prevent infection.

Sources: Resident's clinical records, interviews with RPN, Wound Lead RPN and the DOC.

This order must be complied with by December 6, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.