Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 26, 27, 28, 29, Jul 3, 5, 6, 2012	2012_034117_0021	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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, several Registered Nurses (RN), several Registered Practical Nurses (RPNs), Restorative Care Aid, several Personal Support Workers (PSWs), and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several identified residents, reviewed the minutes of the Behavioural Support Ontario (BSO) team meetings, reviewed the home's nursing staffing schedule for June 2012,reviewed the home's Critical Incident Reports from January 2012 to June 2012, reviewed an identified Critical Incident from December 2011, observed resident care and services.

It is noted that during inspection, five complaint inspections were conducted Log # O-002817-11, # O-000577-12, # O-000792-12, # O-000814-12 and # O-000866-12.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA 2007, section 6 (1) (c) in that the resident's plan of care does not set out clear directions to staff and other who provide care to the resident.

Resident #04 is identified as being at risk for falls. Between March and May 2012, the resident had several falls, with no injuries.

At the time of the inspection, resident #04 mobilized with a wheelchair and had a wheelchair safety belt. The resident states that he/she does not ambulate anymore with a walker because he/she was having too many falls. Resident #04 stated that he/she now uses only a wheelchair with a safety belt to mobilize and that staff come to his/her assistance with transfers.

Restorative Care Aid, an RPN and a PSW confirm that the resident does not ambulate with a walker but is currently using a wheelchair with a safety belt to mobilize. They also state that resident#04 now requires staff assistance with transfers. Room maintenance measures are some of the other fall prevention interventions that interviewed staff state were recently implemented by the home.

Resident #04's current plan of care, reviewed in June 2012, does not identify changes to the resident's mobility, the use of safety devices nor room maintenance measures as fall prevention interventions. [#O-000886-12]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA 2007, section 24 (1) (2) in that three instances of resident to resident abuse were not immediately reported to the Director.

Resident #02 suffers from a neurological disease and has cognitive deficits. He/She is identified as having occasional periods of aggression towards other residents. On two occasions, Resident #02 was physically aggressive and abusive towards other residents.

- On an identified day in March, 2012, Resident #03 wandered into resident #02's room. Resident #03 refused to leave the room. There was a physical altercation between both residents. Resident #02 pushed Resident #03 to the floor. Resident #03 sustained an injury.

- On an identified day in March, 2012, Resident #02 was physically aggressive towards Resident #08. Resident #02 was walking in the hallway. Resident #02 pushed Resident #08 out of his/her way and Resident #08 fell to the floor, sustaining several injuries. Resident #08 was transferred to hospital for further assessment.

The home's Administrator and Director of Care stated during interviews that they were aware of these incidents of resident to resident abuse. The incidents were reported to them, internal investigations into the incidents were conducted and behavioural management interventions were implemented. The Director of Care could not find any records showing that the Director had been immediately notified of the above incidents. No Critical Incident Records were submitted to the Ministry of Health related to these two incidents of resident to resident abuse. The Licensee failed to immediately report these incidents of resident to resident abuse to the Director. [log # O-000792-12 and # O-000814-12]

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 incidents of resident to resident abuse are immediately reported to the Director as identified in the Regulation, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg 79/10, section 98, in that the police force was not immediately notified of two witnessed incidents of resident to resident abuse.

Resident #02 suffers from a neurological disease and has cognitive deficits. He/She is identified as having occasional periods of aggression towards other residents. On two occasions, Resident #02 was physically aggressive and abusive towards other residents.

- On an identified day in March, 2012, Resident #03 wandered into resident #02's room. Resident #03 refused to leave the room. There was a physical altercation between both residents. Resident #02 pushed Resident #03 to the floor. Resident #03 sustained an injury.

- On an identified day in March, 2012, Resident #02 was physically aggressive towards Resident #08. Resident #02 was walking in the hallway. Resident #02 pushed Resident #08 out of his/her way and Resident #08 fell to the floor, sustaining several injuries. Resident #08 was transferred to hospital for further assessment.

The home's Administrator and Director of Care stated during interviews that they were aware of these incidents of resident to resident abuse. The incidents were reported to them, internal investigations into the incidents were conducted and behavioural management interventions were implemented. However, these incidents were not reported to police services. [log # O-000792-12 and # O-000814-12]

Issued on this 6th day of July, 2012

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

Lynn Duchesne #117