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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2015	2015_198117_0003	O-001468-15	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.

This inspection was conducted on the following date(s): January 21 and 22, 2015

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, RAI Coordinator, to a Registered Practical Nurse (RPN), to several Personal Support Workers (PSWs), to the Restorative Care Lead, to a Physiotherapist and to a resident. The inspector also reviewed an identified resident's health care record, observed the provision of care to an identified resident, reviewed an internal incident report and an internal investigation report.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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	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:

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 failed to ensure that the resident's written plan of care sets out clear direction to staff and other who provide direct care to the resident.

Resident #001 has cognitive impairment and responsive behaviours. The current plan of care identifies that Resident #001 can become suddenly physically aggressive towards staff during the provision of personal care, toileting and transfers. Responsive behaviour interventions include the use and application of a protective device to an identified limb during provision of care and transfers to prevent sudden physical aggression.

A review of Resident #001's health care record was conducted by Inspector #117. Documentation indicates that on a specific day in December 2014, PSW staff member S#112 provided personal care to the resident. During the care, the resident became physically aggressive, hitting out at staff and sustaining an injury. A review of the resident's plan of care, in place at the time of the incident, indicated that the resident was known to become physically aggressive during care and transfers and that a protective device was to be applied to the resident's identified limb during transfers. On January 21, 2015, a sign was noted at the head of the resident's bed indicating that the protective device was to be applied during transfers.

On January 21, 2015, staff members PSW S#104, S#107, S#108 and S#109 stated to Inspector #117 that Resident #001 can be physically aggressive during provision of care and transfers. The staff members stated that a protective device is to be applied to the resident's identified limb during the provision of care and transfers to prevent potential injury to the resident and staff. This information was confirmed with the unit RPN S#103

and the home's RAI Coordinator.

On January 21, 2015, the home's RAI Coordinator stated to Inspector #117 the home had conducted an internal investigation into Resident #001's injuries on a specified day in December 2014, when the resident's family expressed concerns related to the injuries. The home's internal investigation concluded that a non-regular staff member, S#112, had provided care to the resident and had not applied the protective device during the provision of care, resulting in the resident's aggression and subsequent injury. The RAI Coordinator further stated that the resident's plan of care was reviewed and it did not identify that the protective device should be applied at all times during the provision of personal care and transfers. The plan identified the need to apply the protective device for transfers only. The RAI Coordinator stated that the plan has since been modified and updated to reflect the resident's current need and use of the protective device at all times during provision of all aspects of care.

Resident #001's written plan of care did not give clear direction to the staff in regards to the use and application of a protective device during the provision of both the resident's care and transfers. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in Resident #001's plan of care is provided to the resident as specified in the plan of care.

Resident #001's plan of care indicates that the resident's family is to be contacted to inform them of changes in the resident's condition. On a specified day in December 2014, Resident #001 sustained an injury during the provision of care when the resident became physically aggressive. Progress notes in the resident's health care record indicate that the resident's injury was immediately reported to the unit RPN who assessed and treated the injury. It was also documented that the RPN completed an internal incident report related to the resident's injury. However, there is no information related to the RPN contacting Resident #001's family in regards to the sustained injury.

On January 21, 2015, the home's RAI Coordinator stated to Inspector #117 the home had conducted an internal investigation into Resident #001's injuries on a specific day in December 2014, 19 days after the injury occured, when the resident's family contacted the home and expressed concerns related to the injury. The RAI Coordinator confirmed that the resident's family had not been notified of the resident's injury. She confirmed that nursing staff did not contact Resident #001's family when the resident had a change of

condition as was stated in the resident's plan of care. [s. 6. (7)]

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 Resident #001's written plan of care sets out clear direction to staff as it relates to the resident's responsive behaviours and related interventions during all aspects of the residents care; as well the licensee is to ensure that Resident #001's care, as identified in the plan of care, is provided to the resident in regards to contacting the resident's family, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a report is sent to the Director with the results of an investigation undertaken under clause (1) (a), and actions taken under clause (1) (b).

As per the LTCHA s. 23 (1) "Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with."

On a specific day in December 2014, the home received an email correspondence from Resident #001's family. The email expressed concerns with the resident's care as the resident had unexplained injury. A picture of the injury was attached to the email correspondence. The next day, the home's administrator forwarded this letter of complaint to the Director, as per legislative requirements under LTCHA s. 22.1, noting that the home was conducting an internal investigation into Resident #001's injury.

On January 21, 2015, the home's Administrator, Director of Care and RAI Coordinator stated to Inspector #117 that Resident #001's injuries had been investigated on a specified day in December 2014, as soon as the family's letter of concern was received by the home. The home's internal investigation concluded that there was no indication of abuse or neglect. The RAI Coordinator stated that Resident #001's family had been contacted and notified of the results of their investigation that same day.

Inspector #117 reviewed the home's investigation report and Resident #001's health care record. The home's actions as well as contacts with the resident's family prior to and after the investigation were documented. The administrator and RAI Coordinator confirmed that no report with the results of the investigation and actions taken by the home, was sent to the Director as required under the legislation. It is noted that the Administrator did send a report of the investigation with actions taken by the home to the Director on January 22, 2015. [s. 23. (2)]

Issued on this 28th day of January, 2015

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

Original report signed by the inspector.