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
Oct 14, 2015	2015_284545_0021	O-002774-15	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

ANGELE ALBERT-RITCHIE (545)

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): September 21 and 22, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), a Restorative Care/BSO Staff Member and Personal Support Workers (PSW).

The inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, staff work routines and schedules, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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. (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 failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident.

Resident #001 was diagnosed with dementia and according to the most recent assessment (September 2015), had responsive behaviours that occurred almost daily, such as wandering, verbal/physical abuse, socially inappropriate/disruptive behavioural symptoms and was resistive to care.

Upon review of a Critical Incident Report submitted to the Director on a specific date in September 2015, it was documented that Resident #002 had reported to a staff member that Resident #001 had tried to strangle him/her at night while he/she was sleeping, on a specific night in September 2015.

On September 21 & 22, 2015, Inspector #545 observed Resident #001 in a private room. A new roommate had been assigned to Resident #002's semi-private room.

One day post incident, a note documented by Geriatric Psychiatry Outreach recommended that Resident #001 continue in a single room to protect other residents, and that one-on-one supervision at night be continued for at least 1-2 weeks to observe behaviours as incidents seem to occur at night.

During an interview with PSW #S107, she indicated that she was not aware of the Resident's sleep disturbance, added that when the Resident was sleeping, she never disturbed him/her as he could become agitated. PSW #S109 indicated to the Inspector that Resident #001 could easily become agitated especially if had a UTI or if another resident was sitting in his/her spot, but was not aware of other behaviours.

RPN #S102 indicated to the Inspector that night time appeared to be a trigger for Resident #001, and if the roommate was up at night using the bathroom, it woke the resident and could make him/her upset and agitated. The RPN indicated that post incident on a specific date in September 2015; the Resident was moved to a private room and one-on-one monitoring was initiated at night to observe the behaviours.

During an interview with RPN #S103, she indicated that Resident #001's plan of care did not include planned care for the Resident in relation to the sleep disturbance, night wandering and agitation behaviour. The RPN added that a natural sleep-aid was prescribed post incident of a specific date in September 2015 but was not processed pending payment from the family. RPN #S103 indicated that she thought the Clinical Coordinator would have updated the plan of care post incident; however she was unable to find the information. She indicated that the plan of care did not indicate reason for moving Resident #001 to a private room, why the resident required close monitoring by staff (one-on-one monitoring at night) and risk he/she was posing to other residents.

The DOC indicated that Resident #001's plan of care did not reflect actual sleep and rest care; that the Resident had been suffering from a sleep disturbance for some time, and that PRN medication had recently been prescribed to address the agitation. The DOC further indicated that it was the home's expectation to provide clear direction to staff in regards to the Resident's sleep disturbance pattern, the possible risk to other residents, the need to monitor more closely at night and that the plan of care should have been updated following the incident of a specific date in September 2015. [s. 6. (1)]

2. The licensee failed to ensure that provision of the care was documented.

In a review of a Critical Incident Report (CIR) submitted to the Director on a specific date in September 2015 it was documented that Resident #002 reported to RPN #S103 on date CIR was submitted that he/she was woken up the previous night by his/her roommate who had both his/her hands around the neck trying to strangle him/her.

Resident #002 was admitted to the home on a specific date in August 2015 and

transferred to a semi-private room with Resident #001 on a specific date in September 2015 on the day shift; and the following day, the Resident reported to a staff member that the roommate had both his/her hands around the neck trying to strangle him/her.

In a review of a progress note dated a specific date in September 2015 it was documented that Resident #002 explained to RPN #S103 that the Resident had informed her that the roommate tried to strangle him/her the night before as he/she slept, information was shared with ADOC and a room switch was to be considered. There was no information indicating if Resident #002 suffered injury during the incident.

During an interview with RPN #S103, she indicated that Resident #002 had told her on a specific date in 2015 that the new roommate had woken him/her up the previous night, with both hands around the neck. The RPN indicated that the Resident demonstrated to her with his/her own hands how Resident #001 strangled him/her. RPN #S103 indicated that she did not formerly conduct an assessment of Resident #002's neck, and that no marks or injuries were noticed on the resident's neck while the resident was speaking to her. She further indicated that she did not document her observation of Resident #002's neck.

The DOC indicated that the home expects every registered staff member to conduct a skin assessment upon hearing of an alleged physical abuse and to document their assessment. After reviewing Resident #002's progress notes, the DOC indicated that the nurse's assessment had not been documented as per the home's expectation. [s. 6. (9) 1.]

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, the planned care for the resident's sleep & rest pattern, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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Issued on this 20th day of November, 2015

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

Original report signed by the inspector.