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

Long-Term Care Homes Division
Long-Term Care Inspections 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
Apr 21, 2016	2016_381592_0007	006276-16	Resident Quality Inspection

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

MELANIE SARRAZIN (592), JOELLE TAILLEFER (211), KATHLEEN SMID (161), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 7, 8, 9, 10, 11, 14, 15, 16, 17, 18 and 21 of March 2016

During the course of the inspection, the inspector(s) also conducted, 11 Critical Incidents inspections Log#: 024390-15 (fall resulting in a transfer to hospital), 007724-16 (staff to resident abuse), 006520-16 (fall resulting in a transfer to hospital), 033690-15 (Resident to resident abuse), 005023-15 (staff to resident abuse), 003893-16 (staff to resident abuse), 004254-15 (injury resulting in a transfer to the hospital), 034175-15 (resident to resident abuse), 015455-15 (fracture-transfer to the hospital), 005686-15 (resident to resident abuse), 004624-15 (care of resident) and two Complaints inspections Log#: 007416-16 (care of resident), 006099-16 (sufficient staffing).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care (ADOC), the Resident Care and Informatics Manager, the RAI MDS Coordinator, the Environmental Service Supervisor, a Physician, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Dietary Aide, Restorative Care members, Housekeeping Aide, Unit Clerk, Personal Support Workers (PSW), Chair of Family Council, a member of Residents' Council, Family Members and Residents.
During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed one meal service, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **7 WN(s)**
- **3 VPC(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN), who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times. (Log #006099-16)

Villa Marconi is a 128 bed Long-Term Care Home.

Inspector #547 reviewed Villa Marconi's RN Staffing Schedule for the period from December 14, 2015 to February 21, 2016.

The following shifts were identified as not having an RN on duty and present in the home:

December 14, 26 and 31, 2015, on the night shift, from 2300 to 0700 hours.
December 19, 20, 25, 27 and 31, 2015, on the evening shift, from 1500 to 2300 hours.
January 11 and 17, 2016, on the night shift, from 2300 to 0700 hours.
On January 16, 19 and 26, 2016, on the evening shift, from 1500 to 2300 hours.
On February 11, 13 and 14, 2016, on the night shift, from 2300 to 0700 hours.
On February 12, 13 and 14, 2016, on the evening shift, from 1500 to 2300 hours.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the Long-Term care home.

Inspector #547 interviewed the Unit Clerk #118, who is regularly in charge of scheduling nursing staff in the home and indicated that none of the absences were due to an emergency.

On March 23, 2016, the Administrator confirmed with Inspector #592 that the above shifts were not considered emergencies related to unforeseen situation.

The scope and severity of this non-compliance was reviewed. All of the identified shifts were night and evening shifts. The absence of a Registered Nurse, who is familiar with the residents that reside in the long term care home, potentially poses a risk to resident safety and affects every resident living in the home. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to Resident #017. (log #006520-16)

On a specific date in February 2016, at a specified time, staff heard resident #017 yelling and found him/her lying beside his/her bed on the floor. Following the incident, the resident was sent to the hospital where he/she was diagnosed with fractures.

The current plan of care for resident #017 indicated the resident was a risk for falls related to unsteady gait, judgment impairment and repeat falls. It further indicated that resident #017 is to be provided with two bed rails up when in bed, a table top and seat belt while in wheelchair. The plan of care further indicated the use of floor mats beside his/her bed and to ensure the bed is at its lowest. It also indicated the use of a bed alarm attached to resident #017 while in chair and bed position.

On March 8 and 15, 2016, Inspector #592 observed resident #017 sitting in his/her wheelchair; the resident did not have any alarm in place.

On March 15, 2016, in an interview with PSW #127 and #128, who are both familiar with resident #017, both confirmed to Inspector #592 that no bed or chair alarm were in use for the resident. PSW #128 further told inspector #592 that resident #017 would not benefit from a bed alarm as he/she stayed in bed all night and did not attempt to get out of bed. In addition PSW #127 told Inspector #592 that resident #017 had a chair alarm in the past but was always removing it, therefore was not effective and was discontinued.

On March 15, 2016, in an interview with RPN #112, she told Inspector #592 that resident #017 is to be provided with a bed alarm when in bed due to being at risk for falls but was unsure about the need of a chair alarm. Inspector #592 reviewed the plan of care with the presence of RPN #112 and was informed that no bed/chair alarm was observed on the resident and that following the staff interviews, it was confirmed that no chair/bed alarm was used for resident #017. RPN #112 told inspector #592 that the plan of care was not clear and that she would have to refer resident #017 to the rehab department in order to have clear directions for the staff members. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to Resident #050 and #051. (log #33690-15)

On a specific date of November 2015, at a specified time, resident #050 pushed resident #051 in the dining room. Resident #051 became agitated and aggressive towards resident #050 and an argument began between both residents. One on one monitoring was initiated for resident #050, after this incident.

The following day, resident #050 was witnessed approaching resident #051 from behind and struck the resident three times with his/her belt, resulting in resident #051 sustaining a laceration and swelling to a specified area. Resident #051 also sustained a fall as a result of the assault.

Four days after, resident #050 was found on the floor on top of resident #051, hitting him/her with a belt. As a result, resident #051 was sent to the hospital for precautions due to blood thinner therapy, swelling and pain to a specified area.

The current plan of care for resident #050 indicated verbal and physical behaviour due to cognitive impairment and that resident tends to target certain residents. The current plan of care further indicated the staff are to keep close supervision.

The current plan of care for resident #051 indicated resistance to care and wandering

behaviours due to cognitive impairment.

On March 17, 2016, Inspector #592 observed resident #050 and #051 sitting in the resident's lounge approximately 10 feet apart.

On March 17, 2016, in an interview with PSW #108 and #142, they both indicated to Inspector #592 that resident #050 was not to be near or in contact with resident #051 due to past history of physical aggression, therefore resident #050 and #051 were monitored closely. They further told Inspector #592 that staff members need to be aware of resident #050 whereabouts to ensure that both residents are kept a distance from each other.

On March 17, 2016, in an interview with the primary PSW #107 for resident #051, she indicated to Inspector #592 that she was not aware of any directions for keeping resident #051 away from resident #050. PSW #143 who was present during the interview stated that she was not aware of any directions regarding resident #051 and #050.

On March 17, 2016, in an interview with RPN #105, she told Inspector #592 that after the incidents, both residents were not left unsupervised and were separated in different areas. RPN #105 further told Inspector #592 that there was no need to keep both residents away from each other as there was a decrease in physical aggression for resident #050.

On March 17, 2016, in an interview with the ADOC, she told Inspector #592 that her expectations from staff was to keep resident #050 and resident #051 away from each other by having no contact and no interactions due to the past history of physical aggression. She told Inspector #592 that she would provide clear direction to staff members as it was not well communicated in the residents plan of care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (Log #033690-15)

On a specific date at a specified time, resident #050 pushed resident #051 in the dining room. Resident #051 became agitated and aggressive towards resident #050 and an argument began between both residents. One on one monitoring was initiated for resident #050, after this incident.

The following day, resident #050 was witnessed approaching resident #051 from behind

and struck the resident three times with his/her belt, resulting of resident #051 sustaining a laceration and swelling to a specified area. Resident #051 also sustained a fall as a result of the assault.

Four days later, resident #050 was found on the floor on top of resident #051, hitting him/her with a belt. As a result, resident #051 was sent to the hospital for precautions due to blood thinner therapy, swelling and pain to a specified area.

The review of resident health care records indicates that one on one monitoring was initiated on the first day following the altercation in the dining room and was kept in place until a specified date in December 2015.

In an interview with PSW #146, she told Inspector #592 that she was the assigned PSW providing one on one monitoring to resident #050 on this specific day when resident #050 was found on the top of resident #051. She told Inspector #592 that she was instructed by the Registered staff members to monitor resident #050 by staying with him/her at all times due to physical behaviours towards resident #051. She further told Inspector #592 that she stepped away from the unit for approximately four minutes while providing the one on one monitoring to resident #050 without notifying any staff members leaving the resident unsupervised.

On March 17, 2016, in an interview with the ADOC, she told Inspector #592 that the home's expectation upon assigning one on one monitoring is for staff member to have the resident monitored at all time and if staff leave the unit, they are responsible to advise the registered staff to ensure the continuous supervision of the resident. The ADOC further told Inspector #592 that there was a PSW staff member assigned on the days that both incidents occurred. She further told Inspector #592 that on the second day following the first incident, she was unable to determine why the PSW assigned the one on one monitoring had left resident #050 unattended. She further told inspector #592 that on the third incident resulting resident #051 to be sent to hospital, the PSW assigned to the one on one monitoring had also failed to follow the plan of care for resident #050, leaving the resident unsupervised without informing any staff members of her absence. [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 the written plan of care for resident #050 and #051, set out clear directions and that the care set out in the plan of care is provided to both residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy and procedure regarding doors to the outside secured area put in place January 2015 was complied with.

O.Reg s.9 (2) identifies that the home shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On March 7, 2016 at approximately 1030 hours, Inspector #547 noted a double set of doors leading to the home's secure outdoor garden area on the first floor. The inside set of doors were noted to be propped open and Inspector #547 then approached the second set of doors that automatically opened to the secured outdoor garden area.

On March 7, 2016 at approximately 1015 hours, Inspector #547 further noted the door leading to a second floor balcony located near the dining/activity room was not locked.

Similarly, on March 9, 2016, at approximately 1500 hours, this same door leading to a second floor balcony was unlocked and unsupervised, again giving unrestricted access to vulnerable residents.

The policy and procedure titled: Outside Area Security policy # LTC-RCM-H-10.10 effective January 2015, regarding the locked outdoor garden and balcony indicated "ensure that stairways and the outside of the home; i.e. balconies, patios, and terraces, will be unlocked or locked to permit or restrict unsupervised access to those areas by residents".
This policy indicated that "Registered staff will: Ensure that all doors leading to secure outside areas; i.e. balconies, patios and terraces are kept locked at specified times and ensure that the door to the outdoor area is re-locked upon completion of resident outdoor activity".

The DOC indicated on March 11, 2016 to Inspector #547 that the second set of doors to the secure outdoor garden area on the first floor is locked at 2000 hours by the evening Charge Nurse as the home implemented a "Building Safety/Security/Key/Fob Control " policy # ADM-VII-010 in September 2013 for the evening Charge Nurse and the night Charge Nurse to complete rounds of the building and recorded at regular intervals (at least every four hours) during the evening and night shifts. The DOC further indicated that the Charge Nurses role on evenings is to start rounds at 2000 hours to lock all balcony and doors to secure outdoor spaces in the home.

On March 15, 2016 Inspector #547 interviewed RN #117 who indicated that she is the regular Charge Nurse for the evening shift and that the first floor doors to the secure garden area do not need to be locked, as it automatically locks at a certain time like the front doors to the building with the sensor. RN #117 indicated that she does not manually lock the second set of doors to the secure outdoor garden area.
RN #117 further indicated that the second floor balcony door near the dining/activity room is not usually unlocked and is to be kept locked.

The ADOC and the Resident Care and Informatics Manager indicated on March 16, 2016, that the home's expectation for doors to balconies and secure outdoor areas are to be locked at 2000 hours, as per the home's policy. [s. 8. (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 the home complied with their written policy regarding doors to the outside secured area, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of the home's policy # LTC-RCM-G10.80 titled "Skin and wound Care Management Protocol" dated on January 2015, was provided by the Resident Care and Informatics Manager. The policy indicated that registered staff will complete a weekly skin assessment utilizing the electronic wound assessment for resident exhibiting altered

skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds.

Review of the quarterly Minimum Data Set (MDS) on a specified date in February 2016, indicated resident #035 has a Stage 1 pressure ulcer.

Review of the progress notes indicated the resident's skin integrity was as followed:

On a specific day in December 2015, resident #035 was identified with a specified body part excoriated and bleeding
21 day later, resident #035 was identified with some redness to the same body part
On a specific day in January 2016, resident #035 was identified with a new open area to a specified body part
Five days later, resident #035 was identified with bleeding to the same body part area measuring an inch deep
The following day, resident #035 was identified with a cut, approximately 4 inches long with minimal bleeding to a new specified body part
On a specific day in February, resident #035 was identified with a new redness within the same body part area

Interviews with PSW #116 and RN #117 revealed the resident has on-going altered skin integrity to specific body parts.

Interview with the Assistant Director of care (ADOC) confirmed the resident's wound was not reassessed at least weekly by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
Interview with the DOC confirmed that the wound assessment should be completed weekly by a member of the registered nursing staff by using a clinically appropriate assessment instrument. [s.50. (2) (b) (i)] (211) [s. 50. (2) (b) (i)]

2. Resident #043 was transferred to the hospital for a ruptured hematoma on a limb on a specific day in March 2015 and was sent back to the home on the next day.

Review of the progress notes revealed that the resident's dressing was changed two days after the resident returned from hospital.

Review of the home's Medicare System Wound Tracker Task and interview with the ADOC indicated that the resident did not received a weekly skin assessment by a

member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment on the following weeks: March 22, April 5, 12, 2015.

Resident #043 was sent to the hospital on a specific day in April 2015 and returned on the same day after surgery.

Review of the home's Medicare System Wound Tracker Task and interview with the ADOC indicated that the resident did not received a weekly skin assessment for the surgical area by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment on the following month of May, June, July, August, September and November 2015 and for a period of three weeks in October and December 2015.

Interview with the DOC confirmed that the wound assessment should be completed weekly by a member of the registered nursing staff by using a clinically appropriate assessment instrument. (Log #004254-15) [s. 50. (2) (b) (i)] (211) [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration are implemented.

Review of the progress notes on two specified dates in December 2015, three specified dates in January and one specific date in February, 2016 and interviews with PSW #116 and RN #117 indicated resident #035 was exhibiting altered skin integrity. Interview with RPN/Resident Care & Informatics Manager revealed the Registered Dietician did not receive a referral for resident's altered skin integrity for the above period.

Interview with the Registered Dietitian (RD) revealed the resident's current plan of care dated on a specified date in February 2016, indicated to provide protein powder at meal times. The RD stated she assumed the resident was still taking the protein powder ordered on on a specified date in February 2013, but the protein was discontinued on a specified date in September 2013 without being notified. The RD confirmed she did not assess the resident's altered skin integrity during the above dates and changes to the resident's plan of care related to nutrition and hydration has not been implemented.

Interview with ADOC confirmed that any residents exhibiting altered skin integrity need to

be refer to the RD. [s. 50. (2) (b) (iii)]

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 receive a skin assessment using a clinically appropriate assessment and by a Registered Dietitian when clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents wheelchair equipment are kept clean and sanitary.

On March 8,10 and 14, 2016 resident #004's wheelchair was noted to have dried food matter to the seat base by Inspector #547. Upon review of the unit's nightly cleaning schedule for walkers and wheelchairs, resident #004 was to have his/her chair cleaned on specific day of the week. Resident #004's wheelchair remains soiled on the day after it was identified on the home's cleaning schedule.

On March 9,10, and 14, 2016 Inspector #547 observed resident #008's wheelchair to be heavily soiled with dried food debris to the wheelchair frame, footrests and seat during a resident interview. Upon review of the unit's nightly cleaning schedule for walkers and wheelchairs, resident #008 was to have his/her chair cleaned on a specific day of the week. Resident #008's wheelchair remained soiled two days after the equipment was suppose to be cleaned and was not cleaned as per the home's schedule.

On March 8 and 10, 2016 Inspector further noted resident #044's wheelchair to be heavily soiled for dried food debris embedded into the wheel and frame of the residents wheelchair. The resident's seat belt was also noted to be heavily soiled with dried food matter embedded into the fabric. Upon review of the unit's nightly cleaning schedule for walkers and wheelchairs, resident #044 was to have the wheelchair cleaned on a specified week day on the night shift.

Inspector #547 interviewed the DOC on March 10, 2016 regarding the cleaning of wheelchairs and walkers. DOC indicated that the resident's chairs should be cleaned as per the schedule on nights. If during the day, staff notice the chairs or walkers to be soiled, they can also wipe them, or identify them to need cleaning. Upon review of Resident #044, was noted in the cleaning binder to have his/her chair cleaned last night, and the resident's chair remains very soiled with dried food matter down the right wheel of his/her wheelchair, seat belt, and chair frame. The DOC indicated that the state of this chair is not acceptable, and that it should have been picked up this morning with day staff, as this resident should not be in a dirty chair. This chair will need pressure washer, deep clean, as the food has dried and crusted on the metal, that no longer can be cleaned with a wipe down. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During the stage one observations, Inspector #547 noted that 17 out of 40 residents utilized two quarter bed rails at all times.

Resident #007 health care records was reviewed and observations were made. The quarter bed rail for resident #007 was observed to be used daily.

On March 11, 2016 Inspector #547 interviewed the Maintenance Supervisor and requested the documented assessment of the resident bed system for resident #007, including any steps to prevent bed entrapment when bed rails are used. The maintenance supervisor reviewed the home's binder for beds that contained the Health Canada guidance document however no individual bed assessments were noted. The maintenance supervisor is new in the home, and asked maintenance staff #113 if the resident's beds with bed rails have been assessed. Maintenance staff #113 indicated that all the beds in the home had been upgraded to new beds in the last year. He further indicated that to his knowledge, the restorative staff do these evaluations.

On March 11, 2016 Inspector #547 interviewed PSW #110 with restorative care in the

home, and she indicated that they do not do bed assessments for bed systems when rails are used. All the residents have new beds and these beds arrived with quarter bed rails attached.

On March 14, 2016 the Maintenance Supervisor and PSW #110 indicated that there has been no bed system evaluation completed to include prevention of resident entrapment or other safety issues related to the use of bed rails including height and latch reliability and that they were in the process of doing them all today.

2. Observation made on March 8, 2016, by Inspector #211, revealed resident #033 right quarter side rail was elevated.

Review of the bed audit completed on March 2016 and interview with restorative care revealed the home received several new beds in 2016 and the measurements for bed entrapment were not performed until March 14, 2016 for these new beds. The restorative care revealed resident #033's bed rails were loose during the above assessment date.

Interview with the Administrator and RPN/Resident Care & Informatics Manager confirmed the bed assessment completed on a specific date in January 2016, by the nurse in the Medicare system is to verify if the residents require bed rails. The bed system evaluation completed by restorative care and the Environmental supervisor was not performed until March 14, 2016, for resident #033 to take into consideration all potential zone of entrapment. [s. 15. (1)] (211) [s. 15. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that its policy to promote zero tolerance was complied with. As per the LTCHA, 2007, S.O. 2007, c. 8, s.20(2)(e), the policy shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

On a specific day in November 2015, resident #050 was witnessed approaching resident #051 from behind and struck the resident three times with his/her belt, resulting of resident #051 sustaining a skin laceration and swelling to a specified body part. Resident #051 also sustained a fall as a result of the assault.

Four days later, resident #050 was found on the floor on top of resident #051, hitting him/her with a belt . As a result, resident #051 was sent to the hospital for precautions due to blood thinner therapy, swelling of a body part and pain to another specified area.

The home's policy indicated the following:

Under Investigation Procedures:

Upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident, the home will immediately commence an investigation. Identifying all those individuals involved, or with information pertaining to the alleged incident, while maintaining confidentiality to the extent possible.

Thoroughly and accurately documenting all pertinent facts of the resident's direct injuries or symptoms on the resident's health record-the names of anyone involved in the suspected abuse or neglect, or any details of the investigation, are not to be included in the resident's health record.

Thoroughly and accurately documenting any information obtained as a result of the investigation, be it verbal or written, indicating time and date, and keeping it in a secure file specific to the incident being investigated. Time the sequence of events when taking statements.

On March 17, 2016, in an interview with the (ADOC), she told inspector #592 that upon becoming aware of the incident of abuse on that specific day in November 2015, she initiated an investigation and that one on one supervision was in place for resident #050 when the incident took place. She further told inspector #592 that she had not kept any written documentation from the incidents and as a result she was unable to provide any

details of the investigations and specific information relating to the time of the sequence, the pertinent facts of the resident's direct injuries and the one on one supervision whereabouts at the time of the incident. She further told inspector #592 that she had not kept any written documentation from the incident. [s. 20. (1)]

2. The licensee has failed to ensure that it complied with its policy to promote zero tolerance as per the LTCHA, 2007, S.O. 2007, c. 8, s.20(1), when the abuse of a resident was not immediately reported to the Director, as indicated under the LTCHA, 2007, S.O. 2007, c. 8, s. 20(2)(d).

According to O.Reg.79/10, s.2.(1) Emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.
Physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

The home's policy on Prevention of Abuse and Neglect of a Resident Policy Number LTC-RCM-G-10.00 (dated on January 2015), indicates under Reporting Resident Abuse and Neglect, that all staff are responsible to immediately inform the Executive Director (ED)/Administrator and/or Charge Nurse of any incident that constitutes resident abuse or neglect.

On a specific day in April 2014, resident #049 arrived at the dining room, crying and saying out loud "I am not a bad person" and reported to RPN #102 that some staff were not treating him/her well, by being physically rough and having an attitude with him/her. Resident #049 reported that one PSW made him/her feel like she doesn't want to care for him/ her. He/She felt he/she was a burden to the PSW workload. Resident #049 also reported to RPN #102 that another PSW was physically abrupt with how he maneuvers him/her limbs, causing him/her pain and discomfort. Resident #049 further reported that he/she had expressed to the PSW several times to stop what he was doing but PSW then got angry at him/her, getting impatient and short tempered saying to him/her "complain to my boss about me and then I won't have to care for you anymore".

The Resident Care and Informatics Manager was made aware of the alleged incident on the next day, by RPN #102 and immediately proceeded to conduct an investigation into the alleged incident.

Following the investigation, the home concluded that PSW staff actions and inactions were considered emotional abuse with the risk of harm to the resident with failure to follow-up on concerns expressed by resident #047 regarding transfers and repositioning practice which cause pain and discomfort to the resident.

In an interview with RPN #102, she told Inspector #592 that resident #049 feelings were hurt and that it was considered emotional abuse. She further told inspector #592 that the home’s expectation is to immediately report the incident to the Managers but did not report the incident until the next morning and therefore did not follow the home's abuse policy. [s. 20. (1)]

Issued on this 18th day of May, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE SARRAZIN (592), JOELLE TAILLEFER (211), KATHLEEN SMID (161), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2016_381592_0007
Log No. / Registre no:	006276-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 21, 2016
Licensee / Titulaire de permis :	VILLA MARCONI LONG TERM CARE CENTER 1026 BASELINE ROAD, OTTAWA, ON, K2C-0A6
LTC Home / Foyer de SLD :	VILLA MARCONI 1026 BASELINE ROAD, OTTAWA, ON, K2C-0A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gaetan Grondin

To VILLA MARCONI LONG TERM CARE CENTER, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

This plan shall include all recruiting and retention strategies and the home's staffing plan to address the backup coverage for managing absenteeism for Registered Nurses to ensure that there is an Registered nurse on site at all times.

This plan must be submitted in writing by April 28, 2016 to:
Lisa Kluke LTCH Inspector by fax :1-613-569-9670

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN), who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times. (Log #006099-16)

Villa Marconi is a 128 bed Long-Term Care Home.

Inspector #547 reviewed Villa Marconi's RN Staffing Schedule for the period from December 14, 2015 to February 21, 2016.

The following shifts were identified as not having an RN on duty and present in

the home:

December 14, 26 and 31, 2015, on the night shift, from 2300 to 0700 hours.
December 19, 20, 25, 27 and 31, 2015, on the evening shift, from 1500 to 2300 hours.
January 11 and 17, 2016, on the night shift, from 2300 to 0700 hours.
On January 16, 19 and 26, 2016, on the evening shift, from 1500 to 2300 hours.
On February 11, 13 and 14, 2016, on the night shift, from 2300 to 0700 hours.
On February 12, 13 and 14, 2016, on the evening shift, from 1500 to 2300 hours.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the Long-Term care home.

Inspector #547 interviewed the Unit Clerk #118, who is regularly in charge of scheduling nursing staff in the home and indicated that none of the absences were due to an emergency.

On March 23, 2016, the Administrator confirmed with Inspector #592 that the above shifts were not considered emergencies related to unforeseen situation.

The scope and severity of this non-compliance was reviewed. All of the identified

shifts were night and evening shifts. The absence of a Registered Nurse, who is familiar with the residents that reside in the long term care home, potentially poses a risk to resident safety and affects every resident living in the home. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Sarrazin

Service Area Office /
Bureau régional de services : Ottawa Service Area Office