Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 5, 2011	2011-034117-0007	Critical Incident Log # O-000899

Licensee/Titulaire

Villa Marconi Long Term Care Center
1026 Baseline Rd
Ottawa, ON K2C OA6
Fax: 613-727-5145

Long-Term Care Home/Foyer de soins de longue durée

Villa Marconi
1026 Baseline Rd
Ottawa, ON K2C OA6
Fax: 613-727-6205

Name of Inspector(s)/Nom de l'inspecteur(s)

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

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Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with the home's the, Director of Care, to a Registered Nurse, to a Registered Practical Nurse, to three Personal Support Workers and to an identified resident.

During the course of the inspection, the inspector reviewed an identified resident's health care record, reviewed the home's Resident Abuse policy #NM-II-R005 and the home's Abuse Prevention Program policy # ADM-VII-005.

The following Inspection Protocol was used during this inspection:

- Personal Support Services
- Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

2 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

(2) Every resident has the right to be protected from abuse.
(4) Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. .

Findings:

- An identified resident suffers from dementia and is known to have physically and verbally aggressive behaviours.

- In May 2011, the identified resident was brought to his / her room by the identified Personal Support Worker. The resident was soiled and required some personal care.
- The identified Personal Support Worker started to provide care to the resident by him/herself. The resident became verbally and physically aggressive during care.
- The identified Personal Support Worker was seen to slap the identified resident's face with an open palm by another Personal Support Worker who was at the resident's room entrance.

Inspector ID #:	117

Additional Required Actions:

VPC #1 - 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 regarding the identified resident's rights are to be protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, 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.

Findings:

- An identified resident suffers from dementia and is known to have physically and verbally aggressive behaviours.
- The resident's plan of care identifies that all of the identified resident's personal care needs are to be done by two staff members at all times.
- In May 2011, the identified resident was brought to his / her room by and identified Personal Support Worker. The resident was soiled and required some personal care.
- The identified Personal Support Worker started to provide care to the resident by him/herself. The resident became verbally and physically aggressive during care.

Inspector ID #:	117

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	**Date of Report:** (if different from date(s) of inspection). May 6, 2011