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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2018	2018_584161_0001	029693-17	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

KATHLEEN SMID (161)

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): on -site January 15 - 19, 2018.

During the course of the inspection, the inspector(s) inspected a critical incident related to a resident to resident altercation.

During the course of the inspection, the inspector(s) reviewed the identified residents' health care records, the home's policy and procedure titled "Behavioural Interventions – LTC-RCM-F-10.20" effective date January 2015, the home's policy and procedure titled "Zero Tolerance for Resident Abuse and Neglect - ADM-VIII-005" effective date May 2013 and salient email correspondence.

During the course of the inspection, the inspector(s) spoke with Behavioural Support Champions, Personal Support Workers, Registered Nursing staff, Manager of Resident Care and Informatics, Director of Care and the home's Administrator.

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.

- **3 WN(s)**
- **0 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The home failed to ensure that interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

On an identified date in 2017 the Manager of Resident Care and Informatics submitted a Critical Incident Report (CIR) to the Director reporting alleged resident to resident physical abuse. A review of the CIR indicated that on an identified date in 2017 resident #001 pushed resident #002 who fell to the floor. Resident #002 sustained an injury and was transferred to hospital. The resident passed away four days later due to complications as a result of the injury.

Resident #001 was admitted to the home on an identified date in 2017 with multiple medical diagnoses that included cognitive impairment with responsive behaviours.

Resident #002 was admitted to the home on an identified date in 2017 from home with multiple medical diagnoses that included cognitive impairment with responsive behaviours.

According to the CIR, on an identified date in 2017 PSW #106 observed resident #001 and resident #002 walking towards each other in the hallway on the resident care area where both residents resided. PSW #106 observed that suddenly, without provocation, resident #001 pushed resident #002 who fell to the floor. Resident #001 continued walking down the hallway. PSW #106 immediately came to the assistance of resident #002 and summoned registered staff member #107. Resident #002 was assessed by the registered nursing staff member and transported, via ambulance, to the hospital. An interview was conducted on January 16, 2018 with PSW #106, at which time the PSW confirmed to Inspector #161 the events as written in the CIR, as those that she observed on an identified date in 2017. During an interview on January 17, 2018 with RPN #107, she indicated to Inspector #161 that she had observed during her shift on the identified date in 2017, that both resident #001 and resident #002 were calmly wandering and pacing in the hallway on the resident care area where both resided.

On January 15, 2018 Inspector #161 reviewed the health care records of resident #001. Since the resident's admission to the home on an identified date in 2017 until the incident

on a subsequent identified date in 2017, resident #001 did not consistently receive regular dosing of prescribed medications due to the resident's frequent refusals. In addition, during the identified time period, resident #001 had one previous incident of physical aggression towards a co-resident and seven incidents of physical aggression towards staff members. A review of resident #001's daily flow sheets indicated inconsistent observations and documentation of the resident's cognitive patterns, mood and behaviours. The plan of care for resident #001 was reviewed and there were no interventions developed nor implemented for the ongoing monitoring of resident #001's whereabouts related to the resident's unprovoked, unpredictable behaviours.

On January 18, 2018 Inspector #161 reviewed the health care records of resident #002. Since the resident's admission to the home on an identified date in 2017 until the incident 13 days later on an identified date in 2017, resident #002 was frequently wandering, pacing, going into co-residents' rooms, resisting redirection and exhibiting agitated behaviours. A review of resident #002's daily flow sheets indicated inconsistent observations and documentation of the resident's cognitive patterns, mood and behaviours. The plan of care for resident #002 was reviewed and there were no interventions developed nor implemented for the ongoing monitoring of resident #002's whereabouts and responsive behaviours.

There were no interventions developed nor implemented to minimize the risk of an altercation between resident #001 and resident #002 nor any other residents. On an identified date in 2017 both residents were wandering and pacing in the same hallway. Resident #001 pushed resident #002 who fell to the floor and sustained an injury. Four days later, resident #002 succumbed to complications of the injury sustained. [s. 55. (a)]

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 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 O. Reg. 79/10 s.8 (1)(b) 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 to be complied with, in that the home failed to ensure compliance with the following policy.

O. Reg. 79/10, s.53(1)(1). Every licensee of a long term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

On January 16, 2018 Inspector #161 asked for and received from the home's Resident Care and Informatics Manager, the home's policy and procedure titled "Behavioural Interventions – LTC-RCM-F-10.20" effective date January 2015. On page two of the document it indicates that PSW's will document on a daily basis, any resident with noted changes in behaviours using Point of Care (POC) and paper documentation and/or verbal report. Appendix 10.20(c) indicates that staff will use concise behavioural documentation notes.

On January 16, 2018 Inspector #161 reviewed the POC flow sheets pertaining to resident #001 and resident #002 from admission to an identified date in 2017. These flow sheets indicated inconsistent observations and documentation of the residents' responsive behaviours. Inspector #161 asked the Behavioural Support Champions/PSW's #104 and #105 to also review the POC flow sheets of resident #001 and resident #002. Both Behavioural Support Champions/PSW's indicated to Inspector #161 that the flow sheets did not accurately reflect the responsive behaviours of resident #001 and resident #002.

On January 16, 2018 the home's Director of Care indicated to Inspector #161 that he was aware that there were gaps in the POC flow sheets of resident #001 and resident #002 pertaining to responsive behaviours. [s. 8. (1) (b)]

WN #3: 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:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was notified immediately of an incident of physical abuse of a resident by another resident that resulted in injury.

On an identified date in 2017 the Manager of Resident Care and Informatics submitted Critical Incident Report (CIR) to the Director reporting alleged resident to resident physical abuse. A review of the CIR indicated that three days prior, resident#001 pushed resident #002 to the floor. Resident #002 sustained an injury and was transferred to hospital. The resident passed away four days later due to complications as a result of the injury sustained.

The CIR was submitted to the Director three days after resident #002 was injured by resident #001. [s. 24. (1)]

Issued on this 29th day of January, 2018

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN SMID (161)
Inspection No. / No de l'inspection :	2018_584161_0001
Log No. / No de registre :	029693-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 29, 2018
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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee is ordered to:

• Review and revise the home's policy and procedure titled "Behavioural Interventions – LTC-RCM-F-10.20" effective date January 2015, to include accurate documentation of residents' responsive behaviours.

• Develop and implement a plan to review, revise and enhance the home's monitoring process to ensure that all residents demonstrating responsive behaviours of physical aggression and other potentially harmful responsive behaviours that put other residents at risk, are identified and assessed by members of the health care team using a multi-disciplinary approach.

• Develop and implement a plan to meet the needs of all residents demonstrating responsive behaviours of physical aggression and other potentially harmful responsive behaviours that put other residents at risk, which includes written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social and environmental.

• Develop and implement a plan to ensure that the Director of Care and/or delegate, will implement a monitoring process to observe, document and attest that the home's revised policy and procedure titled "Behavioural Interventions – LTC-RCM-F-10.20," is understood and applied by the nursing staff on all three shifts. This process will be conducted a minimum of weekly for four weeks and when staff are deemed compliant by the Director of Care and/or delegate, this will be followed by a minimum of monthly checks for 3 months and when staff are deemed to be compliant by the Director of Care and/or delegate, this will be followed by a reassessment of the frequency of checks and any modifications necessary, to ensure compliance, by the home's Administrator in collaboration with the Director of Care and/or delegate.

Grounds / Motifs :

1. The home failed to ensure that interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

On an identified date in 2017 the Manager of Resident Care and Informatics submitted a Critical Incident Report (CIR) to the Director reporting alleged

resident to resident physical abuse. A review of the CIR indicated that on an identified date in 2017 resident #001 pushed resident #002 who fell to the floor. Resident #002 sustained an injury and was transferred to hospital. The resident passed away four days later due to complications as a result of the injury.

Resident #001 was admitted to the home on an identified date in 2017 with multiple medical diagnoses that included cognitive impairment with responsive behaviours.

Resident #002 was admitted to the home on an identified date in 2017 from home with multiple medical diagnoses that included cognitive impairment with responsive behaviours.

According to the CIR, on an identified date in 2017 PSW #106 observed resident #001 and resident #002 walking towards each other in the hallway on the resident care area where both residents resided. PSW #106 observed that suddenly, without provocation, resident #001 pushed resident #002 who fell to the floor. Resident #001 continued walking down the hallway. PSW #106 immediately came to the assistance of resident #002 and summoned registered staff member #107. Resident #002 was assessed by the registered nursing staff member and transported, via ambulance, to the hospital. An interview was conducted on January 16, 2018 with PSW #106, at which time the PSW confirmed to Inspector #161 the events as written in the CIR, as those that she observed on an identified date in 2017. During an interview on January 17, 2018 with RPN #107, she indicated to Inspector #161 that she had observed during her shift on the identified date in 2017, that both resident #001 and resident #002 were calmly wandering and pacing in the hallway on the resident care area where both resided.

On January 15, 2018 Inspector #161 reviewed the health care records of resident #001. Since the resident's admission to the home on an identified date in 2017 until the incident on a subsequent identified date in 2017, resident #001 did not consistently receive regular dosing of prescribed medications due to the resident's frequent refusals. In addition, during the identified time period, resident #001 had one previous incident of physical aggression towards a co-resident and seven incidents of physical aggression towards staff members. A review of resident #001's daily flow sheets indicated inconsistent observations and documentation of the resident's cognitive patterns, mood and behaviours. The plan of care for resident #001 was reviewed and there were no interventions

developed nor implemented for the ongoing monitoring of resident #001's whereabouts related to the resident's unprovoked, unpredictable behaviours.

On January 18, 2018 Inspector #161 reviewed the health care records of resident #002. Since the resident's admission to the home on an identified date in 2017 until the incident 13 days later on an identified date in 2017, resident #002 was frequently wandering, pacing, going into co-residents' rooms, resisting redirection and exhibiting agitated behaviours. A review of resident #002's daily flow sheets indicated inconsistent observations and documentation of the resident's cognitive patterns, mood and behaviours. The plan of care for resident #002 was reviewed and there were no interventions developed nor implemented for the ongoing monitoring of resident #002's whereabouts and responsive behaviours.

There were no interventions developed nor implemented to minimize the risk of an altercation between resident #001 and resident #002 nor any other residents. On an identified date in 2017 both residents were wandering and pacing in the same hallway. Resident #001 pushed resident #002 who fell to the floor and sustained an injury. Four days later, resident #002 succumbed to complications of the injury sustained. [s. 55. (a)]

(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 27, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : KATHLEEN SMID

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