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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 18, 2019	2019_559142_0007	013065-18, 013567-18, 025565-18	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

JANET MCPARLAND (142)

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): March 7th, 8th, 11th-13th, 2019.

During this inspection, the following logs were inspected:
-013065-18 (CIR #2818-000012-18), 013567-18 (CIR #2818-000013-18) and 025565-18 (CIR #2818-000020-18) related to staff to resident alleged abuse/neglect.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Assistant Director of Care (ADOC), Director of Resident Services (DRS), Director of Care (DOC) and the Administrator.

During this inspection, the inspector also reviewed resident health care records, observed staff to resident interactions and reviewed the licensee's incident investigation documents related to the above incidents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 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	Légende 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. (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).

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 has failed to ensure that care set out in the plan of care provided to the resident as specified in the plan.

Mandatory report (Critical incident report (CIR)) #2818-000013-18 was submitted on a specified date to the Director under the Long-Term Care Homes Act, 2007 regarding an incident of alleged abuse whereby an individual informed registered staff that resident #002 reported that a staff member was very rough when transferring resident to bed. The licensee conducted an investigation and concluded that the staff member was not transferring the resident as directed in the plan of care.

Inspector reviewed resident #002’s health record including the plan of care in place at the time of the incident. The plan of care, identifed with a specific date, indicated that the resident was a specific type of transfer.
In interviews with PSW #101, 102, 103 and RPN #108, they indicated that resident had required assistance for transfers for a very long time. The Director of Resident Services indicated to Inspector #142 that the investigation concluded that the staff member was not transferring the resident as directed in the plan of care.

The licensee failed to ensure that the care set out in the plan of care, specifically related to assistance required during transfers was provided to resident # 002 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the following are documented: 1. The provision of care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care.

Mandatory report (CIR #2818-000012-18) was submitted to the Director under the Long-Term Care Homes Act, 2007 on a specific date regarding an incident of alleged staff to resident neglect. As indicated in the CIR, on an identified date, staff alleged that another staff member failed to ensure resident safety and provide care to specific residents.

In review of the point of care (POC) flow sheets for residents #003, #004 and #005, it was noted that on a specific shift a PSW staff member documented entries related to provision of care such as toileting, number of briefs used during shift, rest/sleep and mood/ behaviour prior to an identified time. It was further noted that there was no additional POC documentation for the remainder of the shift for these residents.
In interviews with the ADOC and DRS, they indicated that the expectation is that staff should document on the POC flow sheets near the end of the shift.
The licensee failed to ensure that the provision of care was documented for residents #003, 004 and #005 after a specific time on an identified time. [s. 6. (9) 1.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Mandatory report (CIR) #2818-000012-18) was submitted on a specific date to the Director under the Long-Term Care Homes Act, 2007 regarding an incident of alleged staff to resident neglect. As indicated in the CIR, on an identified date, staff alleged that another staff member failed to ensure resident safety and provide care to specific residents.
In an interview with the DOC, they indicated that an investigation was conducted and that there was no resident neglect.

Inspector reviewed the MOHLTC Critical Incident System and CIR # 2818-000012-18 was not amended with the results of the investigation. [s. 23. (2)]

Issued on this 18th day of March, 2019

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

Original report signed by the inspector.