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 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
Jan 31, 2019	2019_702197_0002	015121-17, 016006-17, 017554-18, 026712-18, 027701-18	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

JESSICA PATTISON (197)

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): January 21, 22, 24 (on-site), 23 and 29 (off-site), 2019

The following critical incidents related to falls that resulted in transfer to hospital and a significant change in residents' health conditions were completed as part of this inspection report:

Log 027701-18 (CI 2818-000028-18)
Log 026712-18 (CI 2818-000027-18)
Log 017554-18 (CI 2818-000015-18)
Log 016006-17 (CI 2818-000012-17)
Log 015121-17 (CI 2818-000011-17)

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

The inspector reviewed policies and procedures related to the home's falls prevention program and resident health care records and observed resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 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 falls prevention and management program was complied with.

O. Reg. 79/10, s. 48 (1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

During an interview with the Director of Care, they indicated that the home's policy and procedures related to falls are currently being reviewed and updated. They went on to say that the current process within the home is to complete a Post-Fall Investigation (PFI) in Mede-care for each resident who has fallen in order to help prevent future falls. The DOC stated that in most cases the PFI is completed right away, but in some circumstances where the resident is immediately sent out to hospital, it would be completed when the resident returns to the home.

On a specified date, resident #001 fell and sustained an injury which required them to immediately be sent to hospital. The resident returned to the home eleven days later. Upon review of the resident's health care record, there was no PFI documented for the resident related to this fall.

Therefore, the licensee failed to ensure that the process of completing a Post-Fall Investigation (PFI) assessment for each fall was complied with.

Please note that there is an outstanding CO (#001) issued under inspection # 2018_597655_0019 dated January 24, 2019 related to O. Reg. 79/10, s. 8 (1)(b) with a compliance due date of February 22, 2019. [s. 8. (1) (a),s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to a) contact the hospital within three calendar days after the occurrence of an incident to determine whether the injury has resulted in a significant change in the resident's health condition and b) inform the Director within 3 business days of an incident where the licensee remains unsure whether the injury has resulted in a significant change in the resident's health condition.

On a specified date, resident #001 fell and sustained an injury for which they were sent to hospital. The Critical Incident Report (CIR) # 2818-000015-18 detailing the incident was submitted to the Director (Ministry of Health and Long-Term Care) eight days later by the Director of Resident Services (DRS).

During an interview with the DRS, they stated that they could not recall why the CIR was submitted 8 days after the incident, but indicated they would look into the matter further. Upon follow-up, the DRS indicated that the home did not become aware of the significant change in the resident's health condition until they spoke to the hospital. No date for this conversation was provided by the DRS, but the progress notes indicate that it occurred eight days after the fall. The inspector then asked the DRS if the home had called the hospital within 3 calendar days after the incident to determine if the resident had a significant change in their health condition due to their injury. The DRS indicated that there was nothing in the progress notes to indicate a call was made and they were not aware of any staff member calling the hospital to get this information.

Therefore, the home did not ensure that the hospital was called within 3 calendar days where they were unable to determine whether a resident had a significant change in their health condition due to an injury for which they were sent to hospital. Subsequently, the home then did not report the significant change in the resident's health condition until 6 business days after the incident. [s. 107. (3.1)]

Issued on this 12th day of February, 2019

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

Original report signed by the inspector.