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
Aug 7, 2019	2019_593573_0019	005947-19, 006987-19, 008432-19, 009634-19	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

ANANDRAJ NATARAJAN (573), EMILY BROOKS (732)

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): July 11, 12, 15 -19 and 22 -26, 2019

The following Critical Incident Logs was inspected during this inspection:
Log #008432-19, related to resident to resident alleged physical abuse.
Log #009634-19, related to allegations of improper/ incompetent treatment or care of a resident that resulted in harm to the resident.
Log #005947-19 and Log #006987-19 related to staff to resident alleged abuse/ neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Services (DRS), the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapy Assistant, The Behavioural Supports Ontario (BSO) Champion, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector reviewed critical incident reports (CIR), resident's health care record and home's internal investigation documentation, as applicable. Reviewed licensee's relevant policies and procedures. In addition, the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interaction.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
1 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003, who is unable to toilet independently, received the assistance from staff to manage and maintain continence.

A critical incident report (CIR) submitted to the Director, indicated that on a specified date and time, resident #003 was found by staff in the washroom, on the toilet, in a sit to stand lift. The resident was scared, asking for help, and stated that they had been left in the lift for a long time.

PSW #116 and PSW #118 told Inspector #732 that they transferred the resident to the toilet, via the sit to stand lift, around a specified time. PSW #118 told Inspector #732 that they went to assist another resident after putting resident #003 on the toilet. PSW #116 told Inspector #732 that PSW #118 needed assistance for another transfer, so told PSW #115 to stay with resident #003 until they were finished toileting. PSW #118 said they instructed PSW #115 to call when resident #003 was finished and needed to be transferred off the toilet.

On the next shift, PSW #124, who was completing their rounds after receiving report, found resident #003 on the toilet, in the sit to stand lift, at a specified time. RPN #119 who assessed the resident said that resident #003 was upset, scared and complained of pain.

The plan of care indicated that resident #003 required assistance to transfer safely on and off the toilet and requires two-person physical assist with sit to stand lift for any transfers.

Resident #003 was transferred to the toilet at a specified time by the staff members and remained on the toilet for approximately two hours and twenty minutes, until found by PSW #124. Therefore, the staff failed to ensure that resident #003, who required assistance for toileting, received the assistance that was needed to manage/ maintain their continence. (Log #005947-19) [s. 51. (2) (c)]

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 residents who are unable to toilet independently some or all of the time, receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a final report to the Director, concerning s. 23 (2) of the Long -Term Care Home Act (LTCHA), was submitted within a period of time specified by the Director.

According to LTCHA 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).

On March 28, 2012, a memorandum from the Director related to reporting investigations under LTCHA s. 23(2) and time frame of final report under O.Reg. 79/10 S.104 (3) was sent to all Long -Term Care Home licensees, Administrators, and Directors of Nursing and Personal Care. In that memo, it indicated that the time specified by the Director, referenced in section 104(3) of the Regulation is 21 days, unless otherwise specified by the Director.

A Critical Incident Report (CIR) was submitted to the Director of the Ministry of Long-Term Care on a specified date alleging staff to resident neglect of resident #003. Upon review of CIR, for inspection # 2019_593573_0019, it was noted that the CIR was not amended to include the results of the licensee's investigation or the long-term actions planned to correct the situation and prevent recurrence. Inspector #732 spoke with the Administrator who informed Inspector #732 of the results of the investigation and the long-term actions planned to correct the situation and prevent recurrence. the Administrator amended the CIR after an interview with the inspector on a specified date. Therefore, the licensee has failed to ensure that a final report to the Director was submitted within 21 days.(Log #005947-19) [s. 104. (3)]

2. The licensee submitted a Critical Incident Report (CIR) on a specified date to the Ministry of Long -Term Care related to allegations of improper/ incompetent treatment or care of resident #002 that resulted in harm to the resident.

The Director of Resident Services (DRS) indicated during an interview on July 26, 2019, with Inspector #573, that an investigation related to the allegations was initiated immediately. The DRS stated that the internal investigation was completed, and the investigation concluded that the allegations were unfounded. Furthermore, the DRS stated to Inspector #573 that the results of the investigation were not reported to the Director and the final report was not submitted within the specified (twenty-one (21) days) time frame.(Log #009634-19) [s. 104. (3)]

Issued on this 8th day of August, 2019

[redacted]

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

Original report signed by the inspector.