Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 19, 2020	2019_683126_0032 (A4)	015589-19, 022925-19	Other

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

Amended by LINDA HARKINS (126) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Due to the current emergency orders in place amid the coronavirus pandemic, we will be extending the Compliance Order(CO) #001 issued under s. 6. 1. (c) and CO #002 s. 31. 1 from Inspection Report #2019_683126_0032 to October 31, 2020.

Please note that Compliance Order #003 was complied with on March 4, 2020, Inspection #2020_627138_0044 by Paula MacDonald, Inspector #138.

Issued on this 19th day of June, 2020 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Amended by LINDA HARKINS (126) - (A4)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): December 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 2019.

The following logs were inspected:

Follow up Log # 015589-19, related to restraint

Complaint Logs # 021342-19,022513-19 and 022572-19 related to resident's care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Director of Resident Services (DOS), the Registered Dietitian (RD), the Human Resources of Residents Services Manager, the Environmental Services Supervisor (ESS), the Physiotherapist, the Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), resident’s families and several residents.

During the course of the inspection the inspectors also observed residents and resident care, reviewed medical health records, resident room’s temperature, and reviewed home policies. The inspectors also conducted a tour of the home, observed meal service, reviewed the menu, observed the opening of resident accessible windows.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Minimizing of Restraining
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **11 WN(s)**
- **6 VPC(s)**
- **3 CO(s)**
- **1 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003's written plan of care sets out clear direction to staff and others who provide direct care to the resident, specifically in relation to the use of bed rails.

Inspector #573 observed resident #003's bed system with two bed rails in use on both sides of the bed frame. The two bed rails were placed in the middle of the bed frame.

Inspector reviewed resident #003's health care record that included resident #003 SDM's written consent and a physician order for the use two bed rails as a physical restraint. Furthermore, a review of resident #003's written plan of care in place, identified that the two bed rails were used as a PASD.

A review of PSWs electronic documentation in point of care (POC) for resident #003, identified the use of two bed rails as a PASD and as a physical restraint.

Inspector spoke with RPN #125 and RPN #135, they indicated that for resident #003 they consider the use of two bed rails as a physical restraint.

On December 16, 2019, Inspector #573 reviewed resident #003's written plan of care in place with the DOC, stated that resident #003's written plan of care did not indicate that the use of two bed rails as a physical restraint. The DOC further stated that resident #003's written plan of care did not provide clear directions to the staff, specifically in relation to the use of two bed rails. (573)

2. The licensee has failed to ensure that there is a written plan of care for resident #005 that sets out clear direction to staff and others who provide direct care to the resident.

On December 9, 2019, Inspector #732 reviewed resident #005's current written plan of care for falls prevention interventions and resident fall risk in relation to an unwitnessed fall on a specific date in 2019. Resident #005's current written plan of care was dated as initiated a specific date in 2019 and did not include a fall risk or interventions in place to prevent falls. Inspector #732 spoke with DOC #100 who informed Inspector that some written plans of care are not up to date due to the transition from MED e-care to Point Click Care (PCC) around that time; as well as the learning curve for staff on inputting information into the new PCC care plans.

Inspector #732 asked DOC #100 where staff should look for information and direction related to resident #005's fall status if it is not in the written plan of care on PCC. DOC #100 explained to Inspector #732 that staff should look at the documentation in progress notes or the Morse Fall Scale assessment.

Inspector #732 reviewed the progress notes of resident #005 around the time of their fall. There was no mention in resident #005's progress notes of falls interventions in place at the time of the fall, or that falls prevention interventions were added to resident #005's written plan of care after their fall. Inspector noted that RPN #122 completed a Morse Fall Scale assessment after resident #005's fall, with a resulting score of 75, indicating resident #005 was at high risk for falls.

Inspector #732 requested, and was provided, by DOC #100, the written plan of care for resident #005 from MED e-care prior to the switch to PCC. RN #114 confirmed with Inspector #732 that this was the most up to date written plan of care for resident #005 prior to the specific date in 2019. The written plan of care from MED e-care was dated a specific date in 2018 and indicated that resident #005 was at high risk for falls as per the falls history and due to visual impairment

as per the specific date in 2018 falls assessment.

RPN #120 told Inspector #732 that there is a binder on the unit that contains the written plans of care for residents. RPN #120 informed Inspector #732 that because of the change from MED e-care to PCC they check the written plan of care first and then go to PCC when requiring information about a resident. Inspector #732 reviewed the binder on the unit and located resident #005's written plan of care. The written plan of care in the binder was the same written plan of care that DOC #100 had provided Inspector #732 and indicated that resident #005 was at high risk for falls.

On December 10, 2019, RPN #113 told Inspector #732 that they do not consider resident #005 a high risk for falls because they are independent, do not use a walker, and do not have unsteady gait. On the same day, RPN #120 told Inspector #732 that in their assessment of the resident, they do not think resident #005 was at high risk for falls and that the resident walks independently, gait is stable, and since they started to work in the home, the resident has had no falls. On December 11, 2019, RPN #121 told Inspector #732 that they also did not believe resident #005 was a high falls risk based off of their assessment of the resident. RPN #121 said that resident #005 mobilizes independently and their gait is stable.

In conclusion, the current written plan of care for resident #005 does not indicate any falls risk or falls prevention interventions and the prior written plan of care indicated that resident #005 was a high risk for falls. Staff have indicated to Inspector #732 that resident #005 is not a high risk for falls.

Therefore, the written plan of care for resident #005 does not provide clear direction to staff and others who provide direct care to the resident. (732)

3. The licensee has failed to ensure that there is a written plan of care for resident #010 that set out clear directions to staff and others who provide direct care to the resident.

Resident #010 health care record was reviewed. It was noted that the resident was known to have an area of altered skin integrity in 2019.

The resident plan of care was reviewed. It was noted in the progress notes dated

a specific date in 2019 by the physician, that the resident has developed an area of altered skin integrity and suggested a specific intervention for resident #010.

The care plan and Kardex dated a specific date in 2019 were reviewed and no documentation was found related to the risk of altered skin integrity or interventions such as the physician suggestion.

Discussion with Registered practical Nurse (RPN) #113 indicated that it is the nurse on the unit that is responsible to update the care plan. RPN #113 indicated that because of the transition of the electronic documentation system in August 2019, that it was possible that the care plans were not updated.

The plan of care for resident #010 did not set out clear direction related to area of altered skin integrity care and interventions. (126)

4. The licensee has failed to ensure that there is a written plan of care for resident #011 that sets out clear directions to staff and others who provide direct care to the resident.

Resident #011 health care record was reviewed and it was noted that resident was known to have an area of altered skin integrity and that the resident's condition changed on a specific date in 2019.

On a specific date in 2019, resident #011's Substitute Decision Maker (SDM) visited resident #011 and staff were not aware of the care that should be provided to the resident and the SDM observed that a specific intervention was not done correctly. The SDM expressed concerns on several occasions related to that specific intervention.

Discussions held with Registered Practical Nurse (RPN) #127, who indicated that they were not provided with specific interventions related to the care of resident #011.

Discussion held with Personal Support Workers (PSWs) #118, #132 and #133, who indicated that they get daily report from the nurse which include specific care needs for residents and intervention. They indicated that if accurate information is not shared at report, then they are not aware. They are not using a Kardex or other documentation that is regularly updated to reflect the actual care needs of

the resident which would include specific interventions.

The care plan of resident #011 was not providing clear directions related to the resident change of condition and to required specific interventions. (126)

5. The licensee has failed to ensure that there is a written plan of care for resident #013 that sets out clear directions to staff and others who provide direct care to the resident.

Resident #013 health care record was reviewed, and it was noted that resident #013 was known to have three areas of altered skin integrity.

In the progress notes dated a specific date in 2019 and a few day later, it was documented that the resident had a specific area of altered skin integrity. In the Weekly Skin Assessment (WSA) dated a specific date in 2019, it was documented that the resident specific area of altered skin integrity was acquired 14 days prior.

Resident #013 care plan was reviewed, and it was documented that one of altered skin integrity area was identified as being on the wrong side.

Discussion held with Registered Practical Nurse (RPN) #125 was aware of the accurate side of the specific area of altered skin integrity area but was not aware of one of the new area.

The plan of care did not provide clear direction related to altered skin integrity areas and specific interventions to meet the resident care needs. (126) [s. 6. (1) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A4)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of resident was included in the resident's plan of care.

The licensee has failed to comply with Compliance Order (CO) #001 issued as a result of Complaint Inspection #2019_593573_0020. The CO report date was August 07, 2019. The CO had a compliance due date of November 07, 2019. The CO was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 31. (1)

The licensee was ordered to specifically comply with the following items:

1. Ensure that if residents are restrained by a physical device as described in paragraph three of subsection 30 (1), the restraining device of the resident is included in their plan of care.

2. Ensure that, for all residents restrained by a physical device, the restraining is included in the resident's plan of care only if all the following are satisfied:
A. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
B. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in item 2 A.

C. The method of restraining is reasonable, considering the resident's physical and mental condition and personal history and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in item 2 A.
D. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
E. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
F. The plan of care provides interventions to ensure that:
(i) The resident is monitored while restrained, in accordance with the requirements provided for in the regulations;
(ii) The resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;
(iii) The resident's condition is reassessed, and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations.

3. Ensure that all staff that provide direct care to residents are educated/ re-educated on the process of restraining residents and on their roles and responsibilities regarding the application of physical devices including but not limited to lap belts.

4. Ensure that a documented record of the educational program is kept, that includes the date, subject heading, educational content and the staff name who have been educated.

5. Implement a system to monitor and evaluate that all physical devices used to restrain a resident are applied according to manufacturer's instructions. Take immediate corrective action if any discrepancies are discovered.

The licensee completed section #2 A, B, C, D, E, section #3 and section #4 of CO #001 from inspection report #2019_593573_0020.

The licensee failed to comply section #1 and also failed to complete all the components included in section #2 F in that: the resident's condition was not reassessed, and the effectiveness of the restraining was not evaluated, in accordance with the requirements provided for in the regulations.

Furthermore, in section #2 F (i) and (ii) was not completed in accordance with the

requirements provided for in the regulations in that the nursing staff failed to document:
(i) The resident's hourly monitoring while restrained
(ii) The resident release from the physical device and the repositioning of the resident at least once in every two hours.

The licensee also failed to complete section #5 of the CO #001 in that no system was implemented to monitor and evaluate, that all physical devices used to restrain the resident where applied according to manufacturer's instructions and no corrective action were taken if any discrepancies was discovered.

In accordance with O. Regulation 79/10, s.110 (2), the licensee shall ensure that where there is a physical device in use as a restraint, that staff monitor the resident every hour in addition to a release and reposition at least every two hours. Further, the resident's condition is reassessed, and the effectiveness of the restraining is evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

In accordance with O. Regulation 79/10, s. 110. (7), every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: All assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning.

Resident #001, #002 and #003 were observed by Inspector #573 on December 06, 10 and 17, 2019, to have wheelchair lap belt applied while seated in their wheelchair. It was confirmed through staff interviews, physician order and the plan of care that the lap belt is used for these residents as a restraint to reduce the risk of injury from falling from the wheelchair.

During an interview, Inspector #573 separately spoke with PSW #101, PSW #107 and PSW #134, they indicated that resident #001, #002 and #003's wheelchair lap belt was consistently being applied when the residents were in their wheelchair. Furthermore, they stated that the restraint hourly monitoring, every application and removal of the residents' lap belt restraint and repositioning of the residents was documented in the point click care (POC).

Inspector #573 spoke with RPN #125, who indicated that they do monitor the residents on restraint, but do not conduct a formal reassessment nor document the resident's condition, and the effectiveness of the restraint for every eight hours.

During an interview with RPN #135 on December 16, 2019, it was indicated to the inspector that the resident's condition is not reassessed, and the effectiveness of the restraint is not evaluated every eight hours, unless the PSW staff reported any concerns with the resident’s restraint.

The records for restraint documentation, for resident #001, #002 and #003 were reviewed for the month of November 07, 2019 to December 10, 2019. The electronic point of care (POC) documentation was used during this time and provides for the hourly recording for the monitoring, including the resident’s response and every release of the device and all repositioning of the resident with the restraint.

For resident #001, it was observed that when the wheel chair lap belt was in use, the documentation does not capture the monitoring and repositioning of resident for November 11, 17, 18, 19, 20, 21, and 22, 2019 (0730 to 1430 hours) and on December 07, 2019 (1530 to 2130 hours).

For resident #002, it was observed that when the wheel chair lap belt was in use, the documentation does not capture the monitoring and repositioning of resident for November 08, 09, 10, 17, 23, 24, 25 and 26, 2019 (1530 to 2030 hours), December 02, 06, and 08, 2019 (1530 to 2030 hours), December 03, 2019 (0730 to 1430 hours) and December 04 and 07, 2019 (0730 to 2030 hours).

For resident #003, it was observed that when the wheel chair lap belt was in use, the documentation does not capture the monitoring and repositioning of resident for November 08, 09, 10, 17, 23, 24, 25 and 26, 2019 (1530 to 2030 hours), December 02, 06, and 08, 2019 (1530 to 2030 hours), December 03, 2019 (0730 to 1430 hours) and December 04 and 07, 2019 (0730 to 2030 hours).

RN #114 and Inspector #573 reviewed the POC documentation for resident #001, #002 and #003 for the month of November 07, 2019 to December 10, 2019. Upon review, the RN stated that for the above identified dates and hours the PSW staff failed to document the monitoring, application, release of the device and

repositioning of the resident in the POC. Furthermore, the RN reviewed resident health care records and were unable to locate any documentation supporting that the registered nursing staff re-assess the resident's condition and evaluate the effectiveness of the restraint every eight hours for the above identified residents.

During this Inspection, Inspector #573 spoke with Director of Care (DOC), it was indicated that the residents with restraint are monitored hourly by the PSW staffs, who document the monitoring, application, release of the device and repositioning of the resident in the POC. The DOC indicated that the registered nursing staff must re assess and record the resident's response, the effectiveness of the restraint every eight hours in the resident's progress notes. Furthermore, the DOC indicated that as per the nursing documentation standards if there is no documentation recorded in the resident's heath care record, then it is not completed.

In relation to CO #001 section #5, the DOC stated to the inspector that they had a plan to implement regular audits by the Occupational therapist (OT) to address section #5 of the CO #001. Furthermore, the DOC stated to the inspector that to date they had not implemented a system to monitor and evaluate, that all physical devices used to restrain the resident where applied according to manufacturer's instructions and no corrective action were taken if any discrepancies were discovered.

As demonstrated in this report the licensee failed to comply section #1, failed to complete all the components included in section #2 F and failed to complete section #5.

In summary, the licensee has failed to comply LTCHA, 2007 S.O. 2007, c.8, s. 31. (1), (2) and (3) in that they failed to ensure that the restraining of resident was included in the resident's plan of care. Further, the provision in the plan of care related to restraints and the requirements related to restraining were not followed, if a resident was restrained. [s. 31. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters (cm).

With the assistance of maintenance lead #111, three windows were opened and measured to open more than 15 cm on second floor.

Fourthteen additional windows were measured by the inspector to open more than 15 cm.

Discussion was held with the administrator who stated that they were aware of a safety memo from Ministry of Long-Term Care sent to the sector in March 2019 regarding the legislative requirements of windows. The administrator stated that they were under the belief that the windows in the home met legislative requirements and only opened a maximum of 15 cm and expressed concerns that some widows could be opened more that 15 cm. [s. 16.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways are kept locked.

Stairwell H is located in the common area in the centre of the home. The door to this stairwell on the first floor, labelled as door H1, was observed to be alarmed but unlocked. When the push bar on door H1 is depressed an alarm sounds and the door opens, providing access to stairwell H.

The H1 door was examined with maintenance lead #111 who stated that door is always to be locked and only unlocked through the door access system. The maintenance lead was unable to explain why the door was unlocked.

The H1 door was also examined with administrator #110 who stated that they were under the belief that the door was locked and was surprised that it was not.

As such, door H1 leading to stairwell H was not locked during the course of the inspection. [s. 9. (1)]

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 all doors leading to stairways must be kept closed and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #10 who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Resident #010 acquired altered skin integrity on a specific date in November 2019 and a Weekly Skin Assessment (WSA) was completed the following day.

Discussion held with Registered Nurse (RN) #114 (Wound Care Champion) indicated that a weekly list of residents with altered skin integrity are sent to each unit. The expectation is that the nurse on the unit will complete the (WSA) and update the plan of care related to altered skin integrity if needed.

Discussion held with Registered Practical Nurse (RPN) # 113 on December 10, 2019. RPN #113 indicated that the WSA was not completed on the specific date that it was due to be done. RPN#113 indicated that the WSA was going to be completed on this date and that the wound was healing well and was probably healed.

The licensee failed to ensure that the Weekly Skin Assessment (WSA) was completed for resident #010.

2. The licensee has failed to ensure that resident #011 who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Resident #011 was known to have altered skin integrity.

Weekly Skin Assessments (WSAs) were reviewed and it was noted that they were not completed on a weekly basis.

Discussion held with Registered Practical Nurse (RPN) #128, indicated that on a weekly basis, a list is provided for whom required a weekly skin assessment. RPN #128 was not aware of the reason why the weekly skin assessment was not done on resident #011 on a specific date in 2019.

The licensee failed to ensure that WSA was completed for resident #011. (Log #021342-19)

3. The licensee has failed to ensure that resident #13 who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Resident #013 was known to have altered skin integrity.

Weekly Skin Assessment (WSAs) documentation was reviewed and it was noted that the weekly (WSA)s was not done on specific dates in 2019.

Discussion held with Registered Practical Nurse (RPN) #125 related to resident #013’s wounds. RPN #125 was not aware that resident #013 altered skin integrity area and weekly assessment was not completed for that week.

The licensee failed to ensure that WSAs were completed for resident #013.

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are available and offered at each meal.

It was observed at two lunch meal services that menu items were not available as per the posted daily and weekly menus. On December 3, 2019, the menu for lunch provided for shrimp spaghetti with alfredo sauce for the regular menu as well as textured modified versions for the minced and pureed textured diets. This was not available to the residents and instead beef ravioli was offered for the regular menu along with textured modified versions for the minced and pureed texture diets. In addition, pureed salami on wheat (sandwich) was not available as per the menu and instead pureed chicken with pureed bread was available. Then on the lunch service on December 9, 2019, the pureed deli sandwich as indicated on the menu was not available and instead pureed chicken and pureed bread was offered. [s. 71. (4)]

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 planned menu items are available and offered at each meal, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining service that includes proper techniques to assist resident #009 with eating, including safe positioning of the resident when assistance is required.

On December 3, 2019, resident #009 was observed to be fed by PSW #107 a meal consisting of regular textured foods while lying in a supine position in a wheelchair in the lounge area outside a dining room. The PSW explained that the resident's wheelchair had broken and the only position that it could accommodate was fully reclined. The PSW also confirmed to the inspector that the resident requires complete assistance with feeding. The Director of Care entered the home area and observed the resident being fed in a supine position however no further action was taken to ensure proper positioning of the resident while eating.

The inspector returned to observe another meal service to ensure the resident was positioned properly for eating and noted that the resident was seated upright in their wheelchair in a proper position for eating. Staff stated that the wheelchair had a temporary fix in place that made it suitable for use during meal times. Another discussion was held with PSW #107 regarding feeding resident #009 while in a supine position and the PSW stated that the resident should have been taken out of the broken wheelchair, put in bed and positioned properly for the meal. [s. 73. (1) 10.]

2. The licensee failed to ensure that resident #006 who required assistance with eating is served a meal when someone is available to provide the assistance.

During the lunch meal service on December 3, 2019, resident #006 was observed to be provided a bowl of soup at 1215 hours and then the entree portion of the meal at 1231 hours. The resident did not eat independently and was not provided with any assistance until 1235 hours, 20 minutes after the soup was delivered, when a staff sat with the resident and began providing feeding assistance to the resident starting with the soup and then moving to the entree. [s. 73. (2) (b)]

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 the home has a dining service that includes proper techniques to assist resident #009 with eating, including safe positioning of the resident when assistance is required, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that staff applied the physical device for restraining a resident in accordance with manufacturer's instructions.

On December 17, 2019, Inspector #573 observed resident #002 and resident #003 sitting in a wheelchair with a front closing lap belt that was not positioned across the hips and had more than five inches gap between the wheel chair lap belt and the resident's hips.

On December 17, 2019, resident #002 and #003's wheelchair lap belt was examined by Physiotherapist (PT) #130 in the presence of the inspector, PT #130 indicated to inspector that the wheel chair seat belt was loose and immediately readjusted the front closing lap belt to fit the residents.

Residents #002 and #003 health care records were reviewed by inspector #573. In both the health records, the use for wheel chair lap belt was identified as physical restraints for the residents.

On December 19, 2019, inspector confirmed with Occupational therapist (OT) #137 that resident #002 was using a specific padded wheelchair lap belt.

Inspector reviewed the specific padded hip wheelchair belt manufacturers' instructions which indicated that "Keep belt tightened during fitting and maintain this tightness during daily use to ensure correct placement. For padded hip belts, the pads will touch when fully tightened".

In the specific pelvic support belt installation and user's instructions, the third warning was as follows "This pelvic support belt must be worn tightly fitted across the lower pelvis or thighs at all times. A loose belt can allow the user to slip down and create a risk of strangulation. Have your seating specialist demonstrate its proper adjustment and use".

On December 19, 2019, Inspector #573 spoke with OT #137, who was an Assistive Devices Program (ADP) authorizer indicated that the expectation regarding the application of the wheelchair lap belt was that it should be one or two fingers gap between the lap belt and the resident's hips. Furthermore, they indicated that the wheel chair lap belt had to be applied properly to fit the resident, not too tight or loose and had to be a snug fit. [s. 110. (1) 1.]

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 staff applied the physical device for restraining a resident in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

Inspector #573 reviewed the licensee's policy titled Restraint and PASD's policy/ procedure #LTC -RCM-E 10.00, the policy indicated that the effective date was January 2015. Furthermore, there was no revision or annual evaluation date in that policy.

Interview between Inspector #573 and the DOC on December 19, 2019, indicated that the licensee's policy titled Restraint and PASD's #LTC -RCM-E 10.00 was not evaluated for the effectiveness annually. Further, the DOC indicated that since January 2015, no record was found for any revision nor the annual evaluation date of the policy. [s. 113. (b)]

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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents is complied with.

On December 17, 2019, at the request of Inspector #573, the DOC provided the licensee's Restraint and PASD's policy/ procedure #LTC -RCM-E 10.00, effective date, January 2015.

Inspector #573 reviewed the Restraint and PASD's policy/ procedure #LTC -RCM-E 10.00 under procedure, it indicated that registered nurse/ registered practical nurse will obtain a written consent (LTC-RCM-E-10.00 b) consent for restraint/ PASD) for the initial restraint use, annually there after and upon any change in the restraint order.

Resident #002 was observed on December 06, 10 and 17, 2019, to have a lap belt applied while seated in a wheelchair. It was confirmed through staff interviews, physician order and the plan of care that the lap belt is used for the resident as a restraint to reduce the risk of injury from falling from the wheelchair.

Resident #002's health care record was reviewed by Inspector #573 and there was no written consent (LTC-RCM-E-10.00 b) from the resident nor from the Substitute Decision Maker (SDM) for the use of the wheel chair lap belt as a restraint.

During an interview with RN #114, they indicated to Inspector #573 that they obtained a verbal consent from resident #002's SDM regarding the use of the wheel chair lap belt as a restraint. Furthermore, RN #114 confirmed that resident #002 health care record does not have a written consent (LTC-RCM-E-10.00 b) for the use of the wheel chair lap belt as a restraint as per the licensee's restraint policy. [s. 29. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #005 had an unwitnessed fall in the bedroom on a specific date in 2019. Resident #005 was assessed by RPN #122 and was noted to be bleeding from a specific body area. Pressure was applied to the area, vital signs taken, and paramedics were called. Physician notes in resident #005's health care record indicated that the fall resulted in an injury to a specific area and required medical interventions.

At the time of the fall, RPN #122 completed a Morse Fall Scale assessment. The total score of the assessment was 75, indicating that resident #005 was a high risk for falls. There were three previous Falls Assessments describing resident #005's fall risk, two were completed in 2018 and one was completed in 2019.

In an interview with RPN #113 on December 10, 2019, they told Inspector #732 that they do not consider resident #005 a high risk for falls. RPN #113 indicated that they did not consider resident #005 a high risk for falls because they are independent, do not use a walker, and do not have unsteady gait.

In an interview with RPN #120 on December 10, 2019, they told Inspector #732 that in their assessment they do not think resident #005 is at high risk for falls. The resident is walking independently, gait is stable, and since they started to work in the home, the resident has had no falls.

In an interview with RPN #121 on December 11, 2019, they told Inspector #732 that they did not believe resident #005 was a high falls risk based off of their assessment of the resident. RPN #121 said that resident #005 mobilizes independently and their gait is stable.

Inspector #732 reviewed resident #005's health care record on December 11, 2019. There were no documented Morse Fall Scale assessments for resident #005 after a specific date in 2019 assessment that indicated the resident was at high risk for falls. Therefore, assessments on resident #005's fall risk by RPN #113, RPN #120, and RPN #121 were not documented. [s. 30. (2)]

Issued on this 19th day of June, 2020 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LINDA HARKINS (126) - (A4)
Inspection No. / No de l'inspection :	2019_683126_0032 (A4)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015589-19, 022925-19 (A4)
Type of Inspection / Genre d'inspection :	Other
Report Date(s) / Date(s) du Rapport :	Jun 19, 2020(A4)
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 :	Cathy Cuccaro

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.6. (1) (c)

The licensee shall ensure that the written plan of care sets out clear directions to staff about the planned care for each resident in relation to falls prevention, skin and wound management, end of life care and the restraining by physical devices by completing the following steps:

1. assess the clarity of directions currently provided to direct care staff for each resident with needs in the areas noted above;

2. in collaboration with direct care staff and immediately upon the identification of gaps in clarity, implement new or revised communication strategies to enhance the quality of directions provided; and

3. evaluate the effectiveness of the new or revised communication strategies by conducting rigorous, documented monitoring activities at least once daily to ensure care for the identified residents is provided as planned.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003's written plan of care sets out clear direction to staff and others who provide direct care to the resident, specifically

in relation to the use of bed rails.

Inspector #573 observed resident #003's bed system with two bed rails in use on both sides of the bed frame. The two bed rails were placed in the middle of the bed frame.

Inspector reviewed resident #003's health care record that included resident #003 SDM's written consent and a physician order for the use two bed rails as a physical restraint. Furthermore, a review of resident #003's written plan of care in place, identified that the two bed rails were used as a PASD.

A review of PSWs electronic documentation in point of care (POC) for resident #003, identified the use of two bed rails as a PASD and as a physical restraint.

Inspector spoke with RPN #125 and RPN #135, they indicated that for resident #003 they consider the use of two bed rails as a physical restraint.

On December 16, 2019, Inspector #573 reviewed resident #003's written plan of care in place with the DOC, stated that resident #003's written plan of care did not indicate that the use of two bed rails as a physical restraint. The DOC further stated that resident #003's written plan of care did not provide clear directions to the staff, specifically in relation to the use of two bed rails. (573)

2. The licensee has failed to ensure that there is a written plan of care for resident #005 that sets out clear direction to staff and others who provide direct care to the resident.

On December 9, 2019, Inspector #732 reviewed resident #005's current written plan of care for falls prevention interventions and resident fall risk in relation to an unwitnessed fall on a specific date in 2019. Resident #005's current written plan of care was dated as initiated a specific date in 2019 and did not include a fall risk or interventions in place to prevent falls. Inspector #732 spoke with DOC #100 who informed Inspector that some written plans of care are not up to date due to the transition from MED e-care to Point Click Care (PCC) around that time; as well as the learning curve for staff on inputting information into the new PCC care plans.

Inspector #732 asked DOC #100 where staff should look for information and direction related to resident #005's fall status if it is not in the written plan of care on PCC. DOC #100 explained to Inspector #732 that staff should look at the documentation in progress notes or the Morse Fall Scale assessment.

Inspector #732 reviewed the progress notes of resident #005 around the time of their fall. There was no mention in resident #005's progress notes of falls interventions in place at the time of the fall, or that falls prevention interventions were added to resident #005's written plan of care after their fall. Inspector noted that RPN #122 completed a Morse Fall Scale assessment after resident #005's fall, with a resulting score of 75, indicating resident #005 was at high risk for falls.

Inspector #732 requested, and was provided, by DOC #100, the written plan of care for resident #005 from MED e-care prior to the switch to PCC. RN #114 confirmed with Inspector #732 that this was the most up to date written plan of care for resident #005 prior to the specific date in 2019. The written plan of care from MED e-care was dated a specific date in 2018 and indicated that resident #005 was at high risk for falls as per the falls history and due to visual impairment as per the specific date in 2018 falls assessment.

RPN #120 told Inspector #732 that there is a binder on the unit that contains the written plans of care for residents. RPN #120 informed Inspector #732 that because of the change from MED e-care to PCC they check the written plan of care first and then go to PCC when requiring information about a resident. Inspector #732 reviewed the binder on the unit and located resident #005's written plan of care. The written plan of care in the binder was the same written plan of care that DOC #100 had provided Inspector #732 and indicated that resident #005 was at high risk for falls.

On December 10, 2019, RPN #113 told Inspector #732 that they do not consider resident #005 a high risk for falls because they are independent, do not use a walker, and do not have unsteady gait. On the same day, RPN #120 told Inspector #732 that in their assessment of the resident, they do not think resident #005 was at high risk for falls and that the resident walks independently, gait is stable, and since they started to work in the home, the resident has had no falls. On December 11, 2019, RPN #121 told Inspector #732 that they also did not believe resident #005 was a high falls risk based off of their assessment of the resident. RPN #121 said that

resident #005 mobilizes independently and their gait is stable.

In conclusion, the current written plan of care for resident #005 does not indicate any falls risk or falls prevention interventions and the prior written plan of care indicated that resident #005 was a high risk for falls. Staff have indicated to Inspector #732 that resident #005 is not a high risk for falls.

Therefore, the written plan of care for resident #005 does not provide clear direction to staff and others who provide direct care to the resident. (732)

3. The licensee has failed to ensure that there is a written plan of care for resident #010 that set out clear directions to staff and others who provide direct care to the resident.

Resident #010 health care record was reviewed. It was noted that the resident was known to have an area of altered skin integrity in 2019.

The resident plan of care was reviewed. It was noted in the progress notes dated a specific date in 2019 by the physician, that the resident has developed an area of altered skin integrity and suggested a specific intervention for resident #010.

The care plan and Kardex dated a specific date in 2019 were reviewed and no documentation was found related to the risk of altered skin integrity or interventions such as the physician suggestion.

Discussion with Registered practical Nurse (RPN) #113 indicated that it is the nurse on the unit that is responsible to update the care plan. RPN #113 indicated that because of the transition of the electronic documentation system in August 2019, that it was possible that the care plans were not updated.

The plan of care for resident #010 did not set out clear direction related to area of altered skin integrity care and interventions. (126)

4. The licensee has failed to ensure that there is a written plan of care for resident #011 that sets out clear directions to staff and others who provide direct care to the

resident.

Resident #011 health care record was reviewed and it was noted that resident was known to have an area of altered skin integrity and that the resident's condition changed on a specific date in 2019.

On a specific date in 2019, resident #011's Substitute Decision Maker (SDM) visited resident #011 and staff were not aware of the care that should be provided to the resident and the SDM observed that a specific intervention was not done correctly. The SDM expressed concerns on several occasions related to that specific intervention.

Discussions held with Registered Practical Nurse (RPN) #127, who indicated that they were not provided with specific interventions related to the care of resident #011.

Discussion held with Personal Support Workers (PSWs) #118, #132 and #133, who indicated that they get daily report from the nurse which include specific care needs for residents and intervention. They indicated that if accurate information is not shared at report, then they are not aware. They are not using a Kardex or other documentation that is regularly updated to reflect the actual care needs of the resident which would include specific interventions.

The care plan of resident #011 was not providing clear directions related to the resident change of condition and to required specific interventions. (126)

5. The licensee has failed to ensure that there is a written plan of care for resident #013 that sets out clear directions to staff and others who provide direct care to the resident.

Resident #013 health care record was reviewed, and it was noted that resident #013 was known to have three areas of altered skin integrity.

In the progress notes dated a specific date in 2019 and a few day later, it was documented that the resident had a specific area of altered skin integrity. In the Weekly Skin Assessment (WSA) dated a specific date in 2019, it was documented

that the resident specific area of altered skin integrity was acquired 14 days prior.

Resident #013 care plan was reviewed, and it was documented that one of altered skin integrity area was identified as being on the wrong side.

Discussion held with Registered Practical Nurse (RPN) #125 was aware of the accurate side of the specific area of altered skin integrity area but was not aware of one of the new area.

The plan of care did not provide clear direction related to altered skin integrity areas and specific interventions to meet the resident care needs. (126) [s. 6. (1) (c)]

In conclusion, the decision to issue this compliance order was based on the following:

The severity of this issue was determined to be an actual risk to the residents and the scope was widespread. The compliance history includes previous non-compliance with section 6. 1. (c) of the LTCHA 2007 as it was issued as part of the Resident Quality Inspection in 2017 (Inspection # 2017_617148_0015) as a Written Notification (WN). This section was issued again as part of a Complaint Inspection in 2017 (# 2017_619550_0009) as a Voluntary Plan of Correction (VPC) and as part a Critical Incident Inspection in 2016 (Inspection # 2016_290551_0031) as a VPC. (732)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A4)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_593573_0020, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Order / Ordre :

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

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

The licensee must be compliant with s. 31 (1) of the LTCHA.

1) Immediately implement a thorough process to assess all the physical devices used to restrain a resident are applied according to manufacturer's instructions. Take immediate corrective action if any discrepancies are discovered. Document the results of this assessment and the actions taken by the licensee to address the identified problems.

2) (a) Implement a rigorous monitoring process on all shifts conducted by the registered nursing staff to ensure that all physical devices used to restraint a resident are applied according to the manufacturer's instructions.

(b) The actions taken by the registered nursing staff to address identified deficiencies must be documented and submitted to the Director of Care (DOC) and the Director of Resident Services (DRS) at the end of every nursing shift.

3) (a) Ensure that the resident’s condition is reassessed, and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations.

(b) Implement a weekly audit by the registered nursing staff responsible for the supervision of resident care to validate that for all residents restrained by the use of a physical device the following are documented: All assessment, reassessment and monitoring, including the resident’s response and every release of the device and all repositioning.

(c) A written record is kept of all audit materials and the actions taken by the by registered nursing staff to address identified deficiencies must be documented and submitted weekly to the Director of Care (DOC) and the Director of Resident Services (DRS).

4) Evidence of the enhanced monitoring process and the actions taken by the Director of Care (DOC) and the Director of Resident Services (DRS) to address identified deficiencies must be documented and submitted to the Administrator for inclusion into the licensee's quality improvement plan for 2020.

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

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

Grounds / Motifs :

1. The licensee has failed to ensure that the restraining of resident was included in the resident's plan of care.

The licensee has failed to comply with Compliance Order (CO) #001 issued as a result of Complaint Inspection #2019_593573_0020. The CO report date was August 07, 2019. The CO had a compliance due date of November 07, 2019. The CO was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 31. (1)

The licensee was ordered to specifically comply with the following items:

1. Ensure that if residents are restrained by a physical device as described in paragraph three of subsection 30 (1), the restraining device of the resident is included in their plan of care.

2. Ensure that, for all residents restrained by a physical device, the restraining is included in the resident's plan of care only if all the following are satisfied:
A. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
B. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in item 2 A.
C. The method of restraining is reasonable, considering the resident's physical and mental condition and personal history and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in item 2 A.
D. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
E. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
F. The plan of care provides interventions to ensure that:
(i) The resident is monitored while restrained, in accordance with the requirements provided for in the regulations;
(ii) The resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;
(iii) The resident's condition is reassessed, and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations.

3. Ensure that all staff that provide direct care to residents are educated/ re-educated on the process of restraining residents and on their roles and responsibilities regarding the application of physical devices including but not limited to lap belts.

4. Ensure that a documented record of the educational program is kept, that includes the date, subject heading, educational content and the staff name who have been educated.

5. Implement a system to monitor and evaluate that all physical devices used to restrain a resident are applied according to manufacturer's instructions. Take immediate corrective action if any discrepancies are discovered.

The licensee completed section #2 A, B, C, D, E, section #3 and section #4 of CO #001 from inspection report #2019_593573_0020.

The licensee failed to comply section #1 and also failed to complete all the components included in section #2 F in that: the resident's condition was not reassessed, and the effectiveness of the restraining was not evaluated, in accordance with the requirements provided for in the regulations.

Furthermore, in section #2 F (i) and (ii) was not completed in accordance with the requirements provided for in the regulations in that the nursing staff failed to document:
(i) The resident's hourly monitoring while restrained
(ii) The resident release from the physical device and the repositioning of the resident at least once in every two hours.

The licensee also failed to complete section #5 of the CO #001 in that no system was implemented to monitor and evaluate, that all physical devices used to restrain the resident where applied according to manufacturer's instructions and no corrective action were taken if any discrepancies was discovered.

In accordance with O. Regulation 79/10, s.110 (2), the licensee shall ensure that where there is a physical device in use as a restraint, that staff monitor the resident every hour in addition to a release and reposition at least every two hours. Further, the resident's condition is reassessed, and the effectiveness of the restraining is

evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

In accordance with O. Regulation 79/10, s. 110. (7), every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: All assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning.

Resident #001, #002 and #003 were observed by Inspector #573 on December 06, 10 and 17, 2019, to have wheelchair lap belt applied while seated in their wheelchair. It was confirmed through staff interviews, physician order and the plan of care that the lap belt is used for these residents as a restraint to reduce the risk of injury from falling from the wheelchair.

During an interview, Inspector #573 separately spoke with PSW #101, PSW #107 and PSW #134, they indicated that resident #001, #002 and #003's wheelchair lap belt was consistently being applied when the residents were in their wheelchair. Furthermore, they stated that the restraint hourly monitoring, every application and removal of the residents' lap belt restraint and repositioning of the residents was documented in the point click care (POC).

Inspector #573 spoke with RPN #125, who indicated that they do monitor the residents on restraint, but do not conduct a formal reassessment nor document the resident's condition, and the effectiveness of the restraint for every eight hours.

During an interview with RPN #135 on December 16, 2019, it was indicated to the inspector that the resident's condition is not reassessed, and the effectiveness of the restraint is not evaluated every eight hours, unless the PSW staff reported any concerns with the resident's restraint.

The records for restraint documentation, for resident #001, #002 and #003 were reviewed for the month of November 07, 2019 to December 10, 2019. The electronic point of care (POC) documentation was used during this time and provides for the

hourly recording for the monitoring, including the resident's response and every release of the device and all repositioning of the resident with the restraint.

For resident #001, it was observed that when the wheel chair lap belt was in use, the documentation does not capture the monitoring and repositioning of resident for November 11, 17, 18, 19, 20, 21, and 22, 2019 (0730 to 1430 hours) and on December 07, 2019 (1530 to 2130 hours).

For resident #002, it was observed that when the wheel chair lap belt was in use, the documentation does not capture the monitoring and repositioning of resident for November 08, 09, 10, 17, 23, 24, 25 and 26, 2019 (1530 to 2030 hours), December 02, 06, and 08, 2019 (1530 to 2030 hours), December 03, 2019 (0730 to 1430 hours) and December 04 and 07, 2019 (0730 to 2030 hours).

For resident #003, it was observed that when the wheel chair lap belt was in use, the documentation does not capture the monitoring and repositioning of resident for November 08, 09, 10, 17, 23, 24, 25 and 26, 2019 (1530 to 2030 hours), December 02, 06, and 08, 2019 (1530 to 2030 hours), December 03, 2019 (0730 to 1430 hours) and December 04 and 07, 2019 (0730 to 2030 hours).

RN #114 and Inspector #573 reviewed the POC documentation for resident #001, #002 and #003 for the month of November 07, 2019 to December 10, 2019. Upon review, the RN stated that for the above identified dates and hours the PSW staff failed to document the monitoring, application, release of the device and repositioning of the resident in the POC. Furthermore, the RN reviewed resident health care records and were unable to locate any documentation supporting that the registered nursing staff re-assess the resident's condition and evaluate the effectiveness of the restraint every eight hours for the above identified residents.

During this Inspection, Inspector #573 spoke with Director of Care (DOC), it was indicated that the residents with restraint are monitored hourly by the PSW staffs, who document the monitoring, application, release of the device and repositioning of the resident in the POC. The DOC indicated that the registered nursing staff must re assess and record the resident's response, the effectiveness of the restraint every eight hours in the resident's progress notes. Furthermore, the DOC indicated that as per the nursing documentation standards if there is no documentation recorded in the resident's heath care record, then it is not completed.

In relation to CO #001 section #5, the DOC stated to the inspector that they had a plan to implement regular audits by the Occupational therapist (OT) to address section #5 of the CO #001. Furthermore, the DOC stated to the inspector that to date they had not implemented a system to monitor and evaluate, that all physical devices used to restrain the resident where applied according to manufacturer's instructions and no corrective action were taken if any discrepancies were discovered.

As demonstrated in this report the licensee failed to comply section #1, failed to complete all the components included in section #2 F and failed to complete section #5.

In summary, the licensee has failed to comply LTCHA, 2007 S.O. 2007, c.8, s. 31. (1), (2) and (3) in that they failed to ensure that the restraining of resident was included in the resident's plan of care. Further, the provision in the plan of care related to restraints and the requirements related to restraining were not followed, if a resident was restrained. [s. 31. (1)]

In conclusion, the decision to reissue this compliance order was based on the following:

The severity of this issue was determined to be an actual risk to the residents and the scope was widespread. This CO was initially served in August 2019, complaint Inspection #2019_593573_0020. As well, the licensee has been issued an additional 8 unrelated COs in which 2 of the COs were referred to the Director within the last 36 months, all of which have since been complied. (573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A4)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee must be compliant with s. 16. of O. Reg 79/10.
Specifically, the licensee shall:
1)Immediately implement a system to evaluate each window that opens to the outside that is accessible to residents as well as ensure that all such windows are prevented from opening more than 15 cm.
2)The system used to evaluate each window will be written and made available to the inspector at follow up.

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

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

Grounds / Motifs :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters (cm).

With the assistance of maintenance lead #111, three windows were opened and measured to open more than 15 cm on second floor.

Fourthteen additional windows were measured by the inspector to open more than 15 cm.

Discussion was held with the administrator who stated that they were aware of a safety memo from Ministry of Long-Term Care sent to the sector in March 2019 regarding the legislative requirements of windows. The administrator stated that they were under the belief that the windows in the home met legislative requirements and only opened a maximum of 15 cm and expressed concerns that some widows could be opened more that 15 cm. [s. 16.]

The decision to issue a compliance order was based on the following:
The severity was determined to be actual risk and the scope was widespread and previous non-compliances were issued in the last 36 months to different subsection. (138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 21, 2020

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

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

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 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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère 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 19th day of June, 2020 (A4)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LINDA HARKINS (126) - (A4)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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