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

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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
Oct 1, 2020	2020_593573_0013	003354-20, 004465-20, 006052-20, 007516-20, 013346-20	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), PAULA MACDONALD (138)

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 21 to 24, 27 to 31, 2020.

Inspector #573 conducted a concurrent complaint inspection #2020_593573_0012 related to the identified Critical Incident System (CIS) logs #013346-20 and #003354-20 during this inspection.

The following logs were completed during this inspection:

- CIS Log #007516-20 related to resident to resident alleged sexual abuse incident.
- CIS Log #004465-20 related to improper care of a resident that resulted in harm to the resident.
- CIS Log (s): #003354-20, #006052-20 and #013346-20 related to an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOCs), Interim Activities Manager, the Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Behavioural Support Ontario (BSO) personnel and a Recreation Aide.

During the course of the inspection, Inspector(s) reviewed resident health care records and the licensee’s policies. The Inspector(s) observed residents, resident home areas, infection control practices. In addition, inspector(s) observed the provision of care to the residents,observed resident to resident interactions and staff to resident interactions.

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

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

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to protect residents #004, #006, and #007 from sexual abuse from resident #002.

A Critical Incident Report (CIR) outlining sexual touching between resident #002 and resident #003 was reviewed. The health care record of resident #002 was reviewed in response. The progress notes outlined several incidents of resident #002's sexual gesturing or touching to other residents.

In relation to two incidents involving resident #004, RN #105 who documented the incidents in the progress notes stated that the touching by resident #002 was sexual in nature. The RN also stated that resident #004 would not be able to consent to any sexual activity with others.

RPN #104 stated that resident #002 had been observed making sexual gestures towards resident #004 and resident #006. Further, RPN #104 and RPN #108 both stated that resident #006 would not be able to give consent to any sexual activity with others.

Further discussions were held with multiple staff who all stated that resident #002 is known to attempt to lure resident to their room. PSW #101 further described an incident in which resident #007 was found sitting with resident #002 on resident #002's bed with resident #002 touching resident #007 sexually before being separated by a staff. Resident #007 would not be able to provide consent to any sexual activity with others.

As such, since resident #004, #006, and #007 are not able to provide consent to sexual activity including gesturing and touching, the licensee failed to protect these residents from sexual abuse by resident #002. (Log #007516-20) [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

A CIR report outlining sexual abuse between resident #002 and resident #003 was reviewed. The health care record of resident #002 was reviewed in response. The progress notes outlined several incidents of sexual gesturing or touching to other residents who were not able to consent to sexual activity with others.

Mandatory reports from the Long-Term Care Home (LTCH) to the Director (Ministry Long-Term Care) were reviewed. No reports were received from the home for the identified incidents of sexual abuse by resident #002.

The DOC #111 was not able to provide confirmation that the Director had been informed of all the incidents of sexual abuse by resident #002.

2. A CIR was submitted to the Director, which described the improper care/ treatment of a resident by a PSW. The PSW left the resident with an injury after providing resident #008's personal care.

A CIR was submitted to the Director after three months related to the identified incident. The licensee failed to ensure that the improper care of resident #008 was immediately reported to the Director. (Log #004465-20) [s. 24. (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 any person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred shall immediately report the suspicion and he information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A CIR was submitted to the Director, related to a fall incident that caused an injury to a resident and which resulted in a significant change in the resident's health status.

Inspector #573 reviewed resident #001's progress notes, which indicated that the resident had a fall incident and unable to walk. The resident was assisted with wheelchair for transfers and mobility. Later the resident was diagnosed with an injury.

A review of the resident #001's health care record in presence of RPN indicated that no post-fall assessment, using a clinically appropriate tool specifically designed for falls was done for the above identified resident's fall incident.

Inspector #573 spoke with DOC #111, they indicated to the inspector that when a resident has fallen, registered nursing staff will complete a clinical post-fall assessment tool in the point click care under the risk management. Further, they stated that no post-fall assessment under the risk management was done for the identified resident's fall incident.

The licensee has failed to ensure that resident #001 had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. (Log #006052-20) [s. 49. (2)]

Issued on this 8th day of October, 2020

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

Original report signed by the inspector.