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
May 4, 2022	2022_597655_0002	012060-21, 013081-21, 001846-22	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

MICHELLE EDWARDS (655), ANANDRAJ NATARAJAN (573)

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): February 24, 25, 28, 2022; and, March 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 2022, on site; and March 15, 2022, off-site.

The following intakes were inspected during this inspection:
Log # 012060-21 - related to a medication incident; and,
Log #'s 013081-21 and 001846-22 - each related to a fall of a resident.

During the course of the inspection, the inspector(s) spoke with residents and family members, the receptionist, personal support workers (PSWs), a nursing student, registered practical nurses (RPNs), and registered nurses (RNs), the Infection Prevention and Control (IPAC) lead and admissions coordinator, a physiotherapist, housekeeping staff, the environmental services manager, ADOC, and Administrator.

In addition, relevant records were reviewed including resident health care records, policies, and incident reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate instrument that is specifically designed for falls.

A resident had a fall and was transferred to hospital for further management. A post-fall assessment using a clinically appropriate tool was not completed for this specific fall incident.

Sources: Resident assessments, progress notes, and interview with ADOC. [s. 49. (2)]

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 when a resident falls, a post-fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy for the medication management system for the accurate administration of all drugs in the home was implemented.

Specifically, the licensee failed to ensure that Policy #3-6, titled "The Medication Pass" (last revised March, 2021) was implemented. This policy outlines the procedural steps required to ensure the accurate administration of medication including checking the resident's medication administration record, following the rights of medication administration, and documenting administration after the resident has received their medication.

1. Inspector #655 observed a nurse administer medications to a resident. At that time, Inspector #655 observed the nurse to prepare and pour the residents medication, and then proceed to document the medications as having been administered, before giving the medications to the resident.

At the time of the medication pass, Inspector #655 observed that one medication was given incorrectly, in that one capsule had been given instead of two as indicated on the medication administration record. The documentation that was completed before the resident received their medications would have been indicative of the resident having received both capsules. Inspector #655 prompted the nurse to review the instructions for administration, at which time the nurse administered the second capsule.

2. A medication incident occurred in which a nurse administered medications to a resident which had not been prescribed to the resident, in error.

According to the ADOC, the results of the investigation into the incident were indicative that the steps outlined in the above-noted policy had not been followed, in that the resident's medication administration record was not checked at the time of the medication pass and the rights of medication administration had not been followed.

Sources: medication observation, interviews with staff, and interviews with ADOC, a review of resident health care records and other relevant records including a critical incident report, internal medication incident report, Policy #3-6 titled "The Medication Pass", and other internal documents related to the medication incident and internal investigation. [s. 114. (3) (a)]

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 written policy for the accurate administration of all drugs in the home is implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

A resident was given a medication which was prescribed for a co-resident, in error. In the resident's progress notes, it was indicated that at the time of the error, the resident experienced a transient change in status. According to the notes, however, the resident returned to baseline shortly thereafter. In a following progress note, the resident was described as being responsive and in stable condition.

During interviews, a nurse and ADOC confirmed that at the time of the incident, the resident had received a medication that was intended for another resident, in error. The ADOC indicated that the resident was monitored following the incident and had experienced no significant adverse reaction as a result of the error.

Sources: interviews with ADOC and other staff, and a review of resident health care records, a critical incident report, an internal medication incident report, and other relevant documents including documents related to the internal investigation of the medication incident, and Policy #3-6 titled "The Medication Pass". [s. 131. (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 no drug is administered to a resident unless the drug is prescribed for the resident, to be implemented voluntarily.

Issued on this 7th day of July, 2022

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

Original report signed by the inspector.