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_0001	010261-21, 011219-21, 013070-21, 017140-21, 017242-21, 017609-21, 018885-21, 019400-21, 019743-21, 001382-22	Complaint

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), MARK MCGILL (733), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint 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 # 010261-21 - related to mobility devices, weight loss, and administration of medications,
Log #011219-21 - related to an injury to a resident of an unknown cause,
Log # 013070-21- related to the plan of care for a resident,
Log# 017140-21, 017242-21, and 017609-21 - related to alleged staff-resident neglect,
Log # 018885-21 and 019400-2 - related to staffing concerns,
Log# 019743-21 - related to alleged staff-resident abuse; and,
Log # 001382-22 - related to the care 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, egistered 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.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Critical Incident Response
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

8 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy related to the assessment of resident's with altered skin integrity was complied with.

Specifically, the licensee failed to ensure that the policy #02-05-04 , titled "Skin Care Program: Assessment and Care Planning" (revised June, 2018), was complied with.

In the above-noted policy, it was indicated that each resident that presents with altered skin integrity was to receive a skin assessment by a registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

During an interview, a nurse indicated to Inspector #655 that the weekly wound assessment tool would be completed by a member of the registered nursing staff for resident's who have an opening in their skin. On the "Weekly Wound Assessment Tool", there were directions which stated that the tool must be completed when skin breakdown is identified, and weekly thereafter, until the affected skin area has healed.

In a resident's health care record, it was indicated that the resident had an alteration in skin integrity.
"Weekly Wound Assessment" tools were found in the resident's health record to be completed every other week.

During an interview, the ADOC indicated to Inspector #655 that when a resident is required to be assessed weekly, that direction is normally added to the resident's medication administration record (MAR). According to the ADOC, in this case, the weekly assessment tool had not been added to the resident's MAR, and as such some assessments may have been missed for that reason.

Sources: interview with a family member, review of a residents health care record, including progress notes and skin assessments, a review of Policy #02-05-04, titled "Skin Care Program: Assessment and Care Planning" (revised June, 2018) and interviews with the ADOC and other staff. [s. 8. (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 the home's policies related to the assessment of resident's with altered skin integrity is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee has failed to ensure that a wheelchair was available at all times to residents who require them on a short-term basis.

A family member of a resident indicated to Inspector #655 that a resident had been left in their bed for a period of time, because the resident's wheelchair required a repair.

In a progress note, it was written that the resident's wheelchair required a repair, and that the home did not have a safe wheelchair for the resident to use. In subsequent progress notes the resident was described as remaining in bed because their wheelchair had not yet been repaired. According to the progress notes, the resident's chair was not repaired until approximately four weeks later.

During an interview, a nurse indicated that for a period of a time, a loaner wheelchair had been given to the resident, but that the loaner chair was actually assigned to a co-resident. The chair was then returned to the vendor, before the residents wheelchair had been repaired.

During an interview, a staff member indicated to Inspector #655 that when the resident's wheelchair needed to be repaired, neither the long-term care home or the wheelchair vendor was able to provide a loaner wheelchair, and that as a result the resident was required to remain in bed for a period of time.

Sources: interview with a family member, review of resident health care records including progress notes, interviews with the ADOC, Administrator, and other staff. [s. 39.]

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 mobility devices, including wheelchairs, are available at all times to residents who require them on a short-term basis, to be implemented voluntarily.

WN #3: 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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, were assessed by a registered dietitian (RD) who is a member of the staff of the home.

Two residents were identified as having altered skin integrity. On review of each of the resident's health care records, there was no indication that the resident had been assessed by a RD when they exhibited altered skin integrity at that time.

During the inspection, the ADOC confirmed that here had been no RD onsite at the long-term care home for a period of time; and, that during that time, not all resident's who would normally be referred to a dietitian had been.

Sources: Interviews with staff and ADOC, a review of resident health care records, including progress notes, skins assessments, and MDS. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity are assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #4: 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. (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 has failed to ensure that residents who require assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

During the supper meal, three different residents who required assistance with eating were served their meal before someone was available to provide the assistance.

The first resident, who required total assistance for meals, was observed to have their main plate in front of them for four minutes before a staff member arrived to feed the resident. Later in the meal, this resident was observed to have their dessert in front of them for five minutes before a staff member arrived to feed them.

The second resident, who required set up and assistance with meals was observed to be sitting at their dining table with their soup in front of them and their main plate on the table out of reach. Four minutes later, after Inspector #178 inquired about the resident's meal, a staff member assisted the resident to eat their soup.

The third resident, who required total assistance with meals, was observed to have their soup and main plate on their dining table without anyone providing assistance to the resident to eat. This residents meal remained on the table in front of them for over five minutes before a staff member arrived to feed the resident.

A staff member indicated that it is not uncommon to deliver the meals to the residents, then afterward go around to feed the residents who require assistance. A nurse indicated that the residents should be fed when the food is brought to them. The ADOC indicated that staff should be serving meals to residents who require assistance only when someone is available to assist the resident.

Sources: Observation of a meal, Interviews with staff and the ADOC. [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 residents who require assistance with eating or drinking are only services a meal when someone is available to provide assistance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian (RD) who is a member of staff of the home was on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During interviews with staff, Inspector #655 was informed that there was no RD in the home. One nurse indicated that when a resident experienced altered skin integrity, weight loss, or another change in status that warranted a referral to a dietitian, they would - at the time of the inspection, refer the resident to their physician instead of the RD, because there was no RD in the home.

Inspector #655 reviewed health care records belonging to two residents. On review of the health care records, no indication of RD involvement could be found despite each of the resident's having exhibited altered skin integrity.

The ADOC indicated to Inspector #655 that for a period of time, the long-term care home was being supported by a corporate RD, but that there was no RD available on site in the home at the time. The ADOC indicated that during that time, some residents that would have otherwise been referred to a dietitian were not, including the above noted residents, and some new admissions.

Sources: Interview with the ADOC and other staff, review of resident health care records, including progress notes, skin and nutrition assessments, and MDS. [s. 74. (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 a registered dietitian who is a member of staff of the home is on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #6: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff released a resident from their restraining physical device and repositioned them at least once every two hours.

In a residents clinical record, it was indicated that the resident required an identified physical device as a restraint. The inspector reviewed the restraint documentation for the resident and found that it did not include the repositioning of the resident every two hours when up in their wheelchair.

During an interview, a PSW who provided care to the resident, stated that the resident's identified restraining physical device was not released and the resident was not repositioned at a minimum of every two hours while sitting in their wheelchair. The inspector spoke with two other staff members, who both indicated that the resident was not able to reposition by themselves while sitting in the wheelchair. By not ensuring the resident was released from the physical device and repositioned at least once every two hours, the resident was placed at risk of experiencing discomfort and skin impairment.

Sources: resident health care records, interviews with staff. [s. 110. (2) 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 staff release residents from their restraining physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #7: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with directions for use specified by the prescriber.

Inspector #655 reviewed a resident's plan of care, including the resident's current medication administration record (MAR). On the resident's MAR, it was indicated that the resident was to receive two capsules of a specified medication at certain times.

During the inspection, Inspector #655 observed a nurse to prepare and administer only one capsule to the resident. During an interview following the observation, the nurse confirmed that they had administered one capsule. The nurse then reviewed the resident's MAR at the inspector's request, at which time they indicated that according to the MAR, the resident was actually to receive two capsules. The nurse administered the second capsule only after Inspector #655 prompted the nurse to review the directions.

Sources: observations of medication pass, interview with a family member, interview with staff. [s. 131. (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 drugs are administered to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for every verbal complaint not resolved within 24 hours, a record was kept outlining the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

A family member indicated to Inspector #655 that they had a complaint. The family member recalled that they had reported their concern to the DOC; at which time they asked that actions be taken to follow-up on their concerns. The family member indicated to inspector #655 that they never received any information from the home that addressed their complaint.

According to a critical incident report related to the same concern, the resident's substitute decision maker (SDM) had already voiced displeasure related to the above-noted complaint.

The ADOC indicated to Inspector #655 that they were aware of the family members concerns and that an investigation had been done. However, the ADOC stated that the investigation was not formal, and could not present a record of the actions taken to resolve the complaint.

Sources: interview with family member, related critical incident report, review resident health care records, including progress notes, review of policy #02-03-02, titled "Complaints procedure" (revised May, 2021), and interviews with the ADOC and other staff. [s. 101. (2) (c)]

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.