Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: August 1, 2023

Inspection Number: 2023-1304-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Villa Marconi Long Term Care Center

Long Term Care Home and City: Villa Marconi, Ottawa

Lead Inspector	**Inspector Digital Signature**
Karen Buness (720483)	Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2023.08.14 10:21:19 -04'00'

Additional Inspector(s)
Kayla Debois (740792)
Marko Punzalan (742406)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 27-30, July 4-7, July 10-13, 2023

The following intake(s) were inspected:

- Intake: 00089536 –Compliance Order Follow-up
- Intake: 00007083 – CIS-Complaint reported by licensee
- Intake: 00020393 – CIS-Fall resulting in a significant change in health status
- Intake: 00021273 – CIS-Fall resulting in a significant change in health status
- Intake: 00021585 – CIS-Suspected resident to resident physical abuse
- Intake: 00022838 – CIS-Suspected resident to resident emotional abuse
- Intake: 00022892 – CIS-Suspected resident to resident physical abuse
- Intake: 00022923 – Complaint related to resident charges
- Intake: 00022984 – Complaint related to resident care and services
- Intake: 00084698 – CIS-Suspected resident to resident sexual abuse
- Intake: 00086217 – Complaint related to falls prevention and resident care and services
- Intake: 00086368 – CIS-Fall resulting in a significant change in health status
- Intake: 00088775 – Complaint related to wound care and resident care and services

- Intake: 00089415 – CIS-Failure/breakdown of air conditioning system
- Intake: 00090675 – CIS-Unexpected Death of a Resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1304-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Karen Buness (720483)

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that behaviour mapping with the Dementia Observation System (DOS) within Point of Care (POC) for resident #004 was documented.

Rationale and Summary:
On a day in February 2023, an alleged incident of resident to resident physical abuse occurred between two residents. Three days later, one of the residents was initiated on DOS observation for seven days. Review of the DOS observation flow sheets on the POC documentation system for a seven day period, indicated that this resident was missing documentation on one day at 2300 hours, another day from

0100 to 0600 hours, and 1400 hours, and a third day from 1500 to 2200 hours.

On a day in March 2023, an alleged incident of resident to resident verbal abuse occurred between the same residents. On that day, the resident who was previously initiated on a DOS was initiated on another one for seven days. Review of the DOS observation flow sheets on the POC documentation system for a seven day period, indicated that this resident was missing documentation on one day at 2300 hours, another day from 0000 to 0600 hours, and 1400 hours, a third day from 1500 to 2200 hours, and a fourth day from 1100 to 1400 hours.

On March 28, 2023, an alleged incident of resident to resident sexual abuse occurred between two residents. Two days later, the same resident was initiated on DOS observation for four days. Review of the DOS observation flow sheets on the POC documentation system for a four day period, indicated that this resident was missing documentation on one of these days at 0000 hours.

In an interview with a PSW, they stated that when a resident is on behaviour mapping, it is the expectation that this documentation is completed every 30 minutes within POC. They acknowledged that this does not always happen.

Failing to ensure resident's care is documented can increase the risk of uncertainty whether the checks were completed or not.

Sources:
Resident's DOS observation documentation within POC, interview with a PSW.

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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to comply with their written policy related to zero tolerance of abuse and neglect.

Rationale and Summary:
On a day in March 2023, an alleged incident of resident to resident sexual abuse occurred between resident two residents. This was observed by a staff member who intervened, and was reported to another staff member the next day, who immediately reported this to the Director of Care (DOC). The

incident was reported to the Director when the DOC was made aware.

The Inspector reviewed the policy 'Zero Tolerance to Resident Abuse and Neglect, revised December 22, 2022'. On page 6 of 16, the policy outlined the procedure that staff members follow when receiving a report of or observing anyone abusing a resident in any manner. This included immediately reporting the abuse as per mandatory reporting.

In an interview with the DOC, they acknowledged that this was not following their policy because the staff member did not report the incident right away. The Assistant Director of Care (ADOC) also acknowledged that the incident should have been reported the same day that it happened.

Failure to report suspected abuse as directed in the Licensee's policy can delay the investigation.

Sources:
Resident's progress notes from PointClickCare, interview with DOC and ADOC, 'Zero Tolerance to Resident Abuse and Neglect, #02-01-02, revised December 22, 2022'.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident, by anyone, that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary:
On two days in June 2023, a resident's electronic records indicated an incident of alleged resident physical abuse, involving this resident and their family member. This incident of alleged abuse was not reported to the Director.

The Administrator acknowledged that the above incident was not reported to the Director.

Not reporting critical incidents immediately to the Director can delay the investigation and response time of the home.

Sources:
Review of CI report system, interview with Administrator, resident's progress notes from PointClickCare.

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