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

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Original Public Report

Report Issue Date: April 5, 2024

Inspection Number: 2024-1304-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Villa Marconi Long Term Care Center

Long Term Care Home and City: Villa Marconi, Ottawa

Lead Inspector	**Inspector Digital Signature**
Pamela Finnikin (720492)	Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2024.05.06 14:56:24 -04'00'

Additional Inspector(s)
Marko Punzalan (742406)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 7-9, 12-16, 20-22, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00097893, Intake: #00102421 - Alleged resident to resident physical abuse.
- Intake: #00102995 - Falls prevention and management
- Intake: #00104032, Intake: #00104092 - Alleged staff to resident neglect or abuse
- Intake: #00101727 - Use of medication resulting in a resident being transferred to hospital.

The following intakes were completed in this Follow Up Compliance Order inspection:

- Intake: #00102906 - Follow-up #001: 1 - O. Reg. 246/22 - s. 12 (1) 1. i. Doors in the home
- Intake: #00102904 - Follow-up #002: 1 - FLTCA, 2021 - s. 6 (7) Plan of care
- Intake: #00102905 - Follow-up #003: 1 - O. Reg. 246/22 - s. 55 (2) (b) (iv) Skin and Wound Program

The following intake was completed in this complaint inspection:

- Intake: #00098922 - Concerns related to resident care concerns

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #003 from Inspection #2023-1304-0004 related to FLTCA, 2021, s. 6 (7) inspected by Pamela Finnikin (720492)

Order #002 from Inspection #2023-1304-0004 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Pamela Finnikin (720492)

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Resident Care and Support Services
Responsive Behaviours

Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviors

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

Rationale and Summary

A resident's health care records indicated that behavioural monitoring was initiated in November 2023, for five days to observe for possible responsive behaviours using the Dementia Observation Scale (DOS).

During the health care records review of the resident, there were three shifts identified where the resident's behaviour was not documented in November 2023.

Interview with a Registered Nurse (RN) confirmed that staff should be documenting hourly observations of the resident's behaviours using a DOS monitoring tool.

During an interview, the Assistant Director of Care (ADOC) indicated that staff were expected to document the behavioural monitoring of the resident using a DOS monitoring tool for the identified timeframe.

As such, the provision of care set out in the resident's plan of care regarding monitoring of responsive behaviours was not documented.

Sources: resident's health care records, interview with an RN and ADOC.

[742406]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

#1

In November 2023, it was reported by a visitor to an RN, that a resident allegedly demonstrated physically responsive behaviours towards three other residents. A visitor submitted a document to the Director of Care (DOC) regarding the alleged incident of responsive behaviour.

In November 2023, two days later, a Critical Incident Report (CIR) was submitted regarding an allegation of physical abuse toward three other residents by a resident.

Interview with Assistant Director of Care (ADOC) confirmed that the incident should have been reported to the Director the same day.

There was a risk that trends might not have been identified when an incident of alleged physical abuse was not reported to the Director immediately as required.

Sources: A resident's health care records and interview with ADOC.

[742406]

#2

Rationale and Summary

Progress notes in June 2023 for a resident in Point Click Care (PCC) confirmed that an alleged physical abuse incident was reported to the Registered Practical Nurse (RPN).

In June 2023, an internal complaint investigation form confirmed that an internal investigation was initiated related to the alleged physical abuse of a resident by a staff member.

The ADOC, DOC and Administrator confirmed in interviews that this incident should have been submitted as a Critical Incident Report to the Director, but was not.

There was a risk that trends might not have been identified when incidents of alleged physical abuse were not reported to the Director as required.

Sources: The resident's health care records including progress notes in PCC, an internal complaint investigation form and interviews with ADOC, DOC and Administrator.

[720492]

#3

Rationale and Summary

A CIR was submitted in December 2023 related to a complaint by a resident's family member of alleged neglect by staff.

In an interview with the DOC, it was confirmed that the CIR should have been submitted as alleged neglect by staff to resident when they were notified on a specific date in December 2023.

In an interview with the ADOC, it was confirmed that the CIR was not submitted to the Director until four days later, and that this was considered late reporting.

There was a risk that trends might not have been identified when an incident of alleged neglect was not reported to the Director immediately as required.

Sources: The CIR, and interviews with the ADOC and DOC.

[720492]

WRITTEN NOTIFICATION: Conditions of licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

Non-compliance related to Follow up #001, Compliance Order #001, Inspection #2023-1304-0004 related to O. Reg 246/22 s. 12 (1) 1. i . Doors in the home with a CDD of January 19, 2024.

Rationale and Summary

A Compliance Plan was submitted by the home in December 2023 and was reviewed by Inspector #720492 in February 2024. The licensee did not implement all required areas of the plan, specifically to fix the locking systems of all exterior leading doors.

A letter received by the home from Chubb Security in January 2024 was reviewed and confirmed that they are in the process of obtaining quotes. The Administrator confirmed that two doors with magnetic locks that are not in resident areas have

been fixed and doors that still need to be fixed are both stairwell doors of the first floor unit, stairwell doors on both second floor units, including the middle stairwell, and stairwell doors on the third floor unit.

A memo to staff was reviewed by Inspector #720492 and stated that if the alarm sounds, staff must go to the doors that lead to the stairwells on resident units and ensure that a resident does not get into the stairwell. This memo was signed by registered staff, including an RN in January 2024.

During the initial tour in February 2024 on the first floor unit, Inspector #720492 went to the west wing stairwell and observed that the door was released after opening it within five seconds and the alarm immediately sounded. The Inspector attempted to open the door multiple times while the alarm was going off and the door remained unlocked. The alarm was turned off by the Inspector using the pin pad and entering the code. The door did not immediately lock and the Inspector could still open the door. A Security Guard who was assigned to the unit, did not come to the sound of the alarm. The Inspector walked to the front entrance area of Amore Unit and the security guard was there. The Inspector asked the security guard what their role was. They stated that they are responsible to ensure the front entrance door is closed (and pointed to the front entrance door that is secured by a pin pad) and to monitor both ends of the hallway where the doors are. The Inspector asked security guard if they heard the alarm sound. They stated yes, that they were on the other end of the unit. The Inspector asked if they are required to come to the sound of the alarm and they said they were walking back this way (pointing to the hallway that the alarm sounded).

In February 2024, Inspector #720492 went to the second floor using stairwell. The door leading to the stairwell on the second floor has a pin pad and can be released when pushed without use of the pin pad. There was no one monitoring the door.

Based on information provided by Administrator, the staff on the floor are responsible to respond when the alarm is sounded. There were no staff around at time of observation.

In February 2024, Inspector #720492 observed both second and third floor resident units with doors leading to the stairwells were all unsupervised. Doors can be released after five to ten seconds when pushed.

In February 2024, Inspector #720492 was on the first floor unit and observed that one security guard was on the unit standing in the entrance area of the unit and there was no security guard on either end of the hallway monitoring the doors leading to the stairwell at time of the observation.

In February 2024, Inspector #720492 went to the second floor unit. There was no staff monitoring the door leading to a specific stairwell. Inspector observed that there was no staff in the hallway on either end of the unit. Inspector held the door at the stairwell open for 10 seconds and the door started flashing and opened. Alarm started to sound. Inspector waited at least 50 seconds for staff to respond to the sound of the alarm.

The staff member who responded stated they are a student Personal Support Worker (PSW) on the floor and did not know the code. The unit RPN came to the door, asked the student PSW what happened and stated they also did not know the code and stated they would need to call the charge nurse. The alarm continued to sound. Another PSW entered different codes into the pin pad and the alarm turned off after the third code attempt. All staff who responded to the alarm at the time of the observation did not check the stairwell to ensure that residents did not exit the door to the stairwell.
During observation, the RPN told other unit staff that they were not aware that there

was a door alarm. Charge nurse RN arrived on unit and told the RPN that they must run to the door when they hear the alarm sound. RN stated that they did not know the door code and that the code changed all the time. A PSW then told the staff what the current code was. Staff did not check the stairwell, and did not ensure residents had not exited out the stairwell door.

In February 2024, Inspector #720492 observed the third floor unit. There were no staff monitoring the doors leading to stairwells at any time during the observation. When asked, staff stated that when the alarm sounds, the charge nurse is responsible for responding to the alarm.

In February 2024, Inspector #720492 observed the second floor unit. At time of observation, there were no staff monitoring the door, and when the door was pushed by the Inspector, the alarm sounded and staff did not respond.

In an interview in February 2024, the Administrator stated that the doors leading to stairwells are not fixed and the first floor has a security guard to monitor the doors. Second and third floor units have daily audits to ensure all doors have been checked and signed for each shift, and the charge nurse responds to any alarm sounded by the door. Staff have been educated on the requirement to respond to any alarm sounding and complete an audit of the unit to ensure residents are safe after any door alarm incident.

In an interview with an RN in February 2024 they stated that they did not check the stairwell and were not aware if any residents had left the unit using the door, and did not complete an audit of the unit for resident safety after they responded to an alarm sounding in February 2024 on the second floor stairwell as directed by management as part of the compliance order plan.
There is a high potential risk for residents as they can access the stairwells because

the doors can be unlocked by pushing the door and are not consistently monitored. Staff are not following training guidelines provided by management related to the compliance order plan.

Sources: Compliance Plan, memo's and training documentation, observations, and interviews with the Administrator and others.

[720492]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

As a required program, O. Reg. 246/22 s. 53 (1) required the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have a policy or strategy in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, staff did not comply with the policy titled Fall Prevention Program, Policy #E-15 (Last Revised March 9, 2023) which was included in the licensee's Fall Prevention and Management Program.

Rationale and Summary

A Critical Incident Report (CIR) confirmed that a resident had an unwitnessed fall in November 2023 resulting in a head injury and transfer to the hospital.

Page one of the Fall Prevention Program policy under Post fall, point one stated that the resident will be assessed after each fall using the Incident-Falls program note heading accessible through the Incident tab in Point Click Care (PCC).

Record review of the Incident Reports tab for a resident confirmed that no incident report or progress notes were completed post fall for the resident in November 2023.

Page two of the Fall Prevention Program policy under Post Fall point six stated initiate head injury routine (HIR) if the resident struck their head during the fall or had an unwitnessed fall.

Record review completed for a resident confirmed that no post-fall head injury routine was initiated for the resident's November 2023 fall.

The ADOC and DOC confirmed in an interview that the Fall Prevention Program, Policy #E-15 was not followed and that a HIR and incident report was not completed for the resident's fall in November 2023.

The resident was at high risk of falls. Failure to complete a HIR and incident report as per policy could delay identifying risk factors and injuries, and impede required falls prevention interventions to mitigate the risk of falls.

Sources: Record review for a resident, CIR, Fall Prevention Program policy #E-15,

interviews with the ADOC and DOC.

[720492]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has 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.

Review of a Critical Incident Report (CIR) confirmed that a resident had an unwitnessed fall in November 2023 resulting in a transfer to the hospital.

Review of progress notes confirm that the resident had a previous fall the same evening, but there was no documentation for the resident's second fall on a specific day in November 2023 by registered staff.
Review of assessments for the resident confirmed that no post fall assessment documentation was found for resident's November 2023 fall.

Interviews conducted with ADOC and DOC confirmed that a post-fall assessment

was not completed for resident's fall on a specific day in November 2023.

There was risk to the resident as there was no documentation related to the resident's fall or contributing factors to prevent further falls and identify if an injury occurred to the resident.

Sources: Resident's health care records, review of the CIR, interviews with ADOC, DOC and others.

[720492]

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident.

Rationale and Summary

An internal investigation initiated in June 2023 by ADOC confirmed alleged physical abuse by an unidentified staff member to resident, resulting in a bruise to their leg.

There was no documentation of the police being notified of the incident.

Progress notes for the resident confirmed that an alleged physical abuse incident occurred but there was no documentation that the police were called.

An internal complaint investigation form did not include that the police were notified of the alleged physical abuse incident.

During interviews, the ADOC and Administrator confirmed that police were not notified of the alleged physical abuse incident that occurred in June 2023.

Failure to notify the police of an alleged abuse incident places risk in the delay of appropriate investigation.

Sources: Resident's health care records, investigation form, interviews with ADOC and Administrator.

[720492]