Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 7, 2013 | 2012_193150_0009 | 002420-12 | 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**

CAROLE BARIL (150)

## 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): December 13, 2012**

**During the course of the inspection, the inspector(s) spoke with the Clinical Manager, Registered Practical Nurse, Resident Assessment Instrument Coordinator, Personal Support Worker, Environmental staff and the resident.**

**During the course of the inspection, the inspector(s) reviewed the resident's health care records, the home's fall prevention and management program and the Behaviour Support team action plan specific to the resident, observed the resident's activities.**

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

**Falls Prevention**

**Reporting and Complaints**

**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4);**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c8, s.107 (3) 4 in that a critical incident following a fall and for the resident to be transferred to the hospital was not immediately reported to the director.

On a identified date in December 2012, progress notes indicate that the resident#1 was found on the floor in sitting position. Resident was shaking, staff transferred the resident to the chair. Charge nurse called to assess the resident and noted bruises on the hands and legs.

The clinical coordinator states that this was an unwitnessed fall and she assessed the resident. The resident was not complaining of any pain, colour was pale and the resident was weak and she decided to transfer the resident to the hospital for assessment with the consent of the resident's family member.

The resident was admitted to the hospital with a head injury.

Six days later, the resident returned from hospital.

The clinical coordinator states that the resident had no injury but was transferred at the hospital for assessment.

The clinical coordinator confirmed that there was no critical incident report submitted to the Director. [s. 107. (3) 4.]

Issued on this 11th day of January, 2013

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