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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jul 8, 15, 2013	2013_198117_0012	O-000417-13, O-000565-13	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

LYNE DUCHESNE (117)

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): June 27, 2013

Two critical incident reports were inspected Log # O-000417-13 and Log #O-000565-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care and Informatics Manager (RCIM), several Registered Practical Nurses (RPN), several Personal Support Workers (PSWs) and an identified resident.

During the course of the inspection, the inspector(s) reviewed the health care records of two identified residents, examined an identified resident's wheelchair, reviewed two critical incident reports, reviewed the home's Head Injury Routine form, reviewed the home's policies entitled Resident Abuse # NM-II-R005, Resident Safety Program for Lifts, Transfers and Repositioning # HS-XVIII-020, Staff Zero Lifting # HS-XVIII-040, Continence Care Bowel # NM-II-C090 and Continence Care Bladder #NM-II-C085.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. c. 8, s. 6 (7) in that Resident #001 did not receive toileting care as specified in the resident's plan of care.

Resident #001 is identified as requiring a 2-person mechanical lift transfer for all of his/her transfers, including transfers for toileting. The plan also identifies that the resident is not to be left unattended when being toileted.

On a specified day in May, 2013, Resident #001 was transferred on to the toilet of the unit's tub/shower room for toileting via the aid of a mechanical lift by staff members #100 and #101. Staff member #101 left the resident to go on a scheduled break, leaving staff member #100 with the resident. Staff member #100 then left Resident #001 seated on the toilet to go and give a bed bath to another resident. Staff member #100 did not communicate to any other staff member that Resident #001 was seated on the toilet.

One hour later staff member #102 approached the unit RPN and Resident Care and Informatics Manager (RCIM), inquiring as to the location of Resident #001 as he/she was not in the unit dining room for the lunch time meal service. Staff member #102 consulted with staff member #100 as to the resident's location. Staff member #100 could not recall the resident's location. This was reported to the unit RPN and RCIM. A unit search was initiated.

Approximately ten minutes later, Resident #001 was found by the RCIM in the tub/shower room. The resident was seated on a toileting sling, on the toilet. The toileting sling was attached to a mechanical lift. The resident was calm. He/She was assessed and no injuries were noted. The resident would not have been able to use the call bell or call out for help if needed due to his/her advanced cognitive impairments.

Resident #001 did not receive toileting care needs as per his/her plan of care as the resident was left seated on the toilet, unattended for approximately 70 minutes. [s. 6. (7)] log # O-000417-13

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 the nursing staff follow the resident's plan of care related to toileting and that staff be in attendance to the resident during toileting, to be implemented voluntarily.

WN #2: 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 failed to comply with the O.Reg 79/10, s.8 (1) b in that where the Act of 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, is complied with.

As per O.Reg 79/10 s. 49, the long-term care home is to have a Falls Prevention and Management program.

As per O.Reg 79/10 s.49 (2) the Falls Prevention Program "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".

The home has a Head Injury Routine assessment form that is to be used to assess and monitor residents after they have sustained a fall. Residents' blood pressure, pulse, respirations, pupils, grip, level of consciousness and other symptoms (e.g. nausea, headache, and tremors) are to be monitored as follows:
- 1st hour – every 15 minutes
- Next 3 hours – every hour
- Next 20 hours – every 4 hours

On a specified day in June, 2013, Resident #002 was found on the floor of his/her bedroom. The resident had sustained an unwitnessed fall. The resident was assessed; no injuries were noted. He/She was placed on the home's Head Injury Routine for monitoring. The Head Injury Routine form and progress notes document that the resident was assessed for the 1st hour, every 15 minutes and then every hour for the next 3 hours. The last assessment was at 20:50hrs. As per the Head Injury Routine form protocol, Resident #002 should have been assessed at 1am and at 6am during the night shift. No notes were found in the resident's chart nor on the Head Injury Routine form to indicate the ongoing assessment of Resident #002 during the night shift.

The morning after the fall, the resident was assessed when his/her morning medications were administered. Approximately 10 minutes later, the resident had a witnessed fall. The resident sustained injuries. Resident #002 was also disorientated and had fluctuating vital signs. The resident was transferred to hospital for further

assessment.

Nursing staff did not comply with the home's Head Injury Routine in that Resident #002 was not monitored during the identified night shift in June 2013. [s. 8. (1)]

log # O-000565-13

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 Head Injury Routine are implemented, that assessments are completed as per the protocol and documented on the appropriate form as per the home's policy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. c. 8, s 19 (1) in that Resident #001 was not protected from neglect when he/she was not toileted by staff as specified in his/her plan of care and when the licensee did not immediately report to the Director the incident of neglect.

Neglect is defined in the O.Reg 79/10 as being " the failure to provide a resident with the treatment, care, services or assistance required for health , safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well -being of one or more residents."

1. The licensee failed to ensure that staff provide care to Resident #001 as specified in the resident's plan of care.

Resident #001 has advanced cognitive impairments and is identified as requiring a 2-person mechanical lift transfers for all of his/her transfers, including transfers for toileting. The plan care also identifies that the resident is not to be left unattended when being toileted.

On a specified day in May 2013, Resident #001 was transferred on to the toilet of the unit's tub/shower room for toileting via the aid of a mechanical lift by staff members #100 and #101. Staff member #101 left the resident to go on a scheduled break, leaving staff member #100 with the resident. Staff member #100 then left Resident #001 seated on the toilet to go and give a bed bath to another resident. Staff member #100 did not communicate to any other staff member that Resident #001 was seated on the toilet when he/she left to go give care to another resident.

One hour later, staff member #102 approached the unit RPN and RCIM, inquiring as to the location of Resident #001 as he/she was not in the unit dining room for the lunch time meal service. Staff member #102 consulted with staff member #100 as to the resident's location. Staff member #100 could not recall the resident's location. This was reported to the unit RPN and RCIM. A unit search was initiated.

Approximately 10 minutes later, Resident #001 was found by the RCIM in the tub/shower room. The resident was seated on a toileting sling, on the toilet. The toileting sling was attached to a mechanical lift. The resident was calm. He/She was assessed and no injuries were noted. The resident would not have been able to use the call bell or call out for help if needed due to his/her advanced cognitive

impairments.

Resident #001 was neglected as he/she did not receive toileting assistance as identified in his/her plan of care. The resident was left seated on a toileting sling, on a toilet, with the sling attached to a mechanical lift, unattended for approximately 70 minutes, putting the resident at risk for potential harm and injury.

The home did conduct an internal investigation into the incident of neglect. Staff member #100 was disciplined as per the home's internal processes.

2. The licensee failed to report to the Director an incident of neglect of a resident that resulted in harm or risk of harm to Resident #001.

The home reported the above incident of neglect to the Director on a specified day in May 2013 through the Critical Incident Reporting system. On June 27, 2013, the home's Administrator confirmed to Inspector #117, that the home reported the incident of neglect 7 days after the occurrence of the incident. The home did not immediately report the incident of neglect to the Director as per legislative requirements. [s. 19. (1)] log # O-000417-13

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 are protected from neglect, that incidents of neglect are to be immediately reported to the Director as per legislative requirements and that residents receive toileting assistance care as identified in their plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
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. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. c.8, s. 24 (1) 2 in that the home did not immediately report to the Director an incident of neglect of a resident that resulted in harm or risk of harm.

On a specified day in May, 2013, Resident #001 was found to seated on the toilet of the tub/shower room. The resident was seated on a toileting sling, on the toilet. The toileting sling was attached to a mechanical lift. The resident had been transferred on the toilet and was left unattended for 70 minutes before being found by the home's Resident Care and Informatics Manager (RCIM). The resident was calm and did not have any injuries. The resident has advanced cognitive impairments and is unable to use a call bell or call for assistance. The resident was left unattended, on the toilet, seated on a toileting sling attached to a mechanical lift for 70 minutes and was at risk of potential harm.

The home reported the incident to the Director on a specified day in May 2013 through the Critical Incident Reporting system. On June 27, 2013, the home's Administrator confirmed to Inspector #117, that the home reported the incident of neglect 7 days after the occurrence of the incident. The home did not immediately report the incident of neglect to the Director as per legislative requirements. [s. 24. (1)] log # O-000417-13

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 that the home immediately notify the Director of any incidence of suspected, witnessed or alleged incidence of neglect, to be implemented voluntarily.

Issued on this 15th day of July, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Lynn Duchesne #117