Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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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 27, 2014	2014_288549_0005	0-000045-14	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

RENA BOWEN (549)

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): January 22 and 23,2014

During the course of the inspection, the inspector(s) spoke with the Administrator (ADMIN),the Director of Care (DOC), Resident Care & Informatics Manager, RAI Coordinator, a Registered Nurse(RN), a Registered Practical Nurse (RPN), Personal Support Worker(PSW) and Resident #1

During the course of the inspection, the inspector(s) Reviewed Resident #1's health care record including, the home's Complaints Policy, the Administrator's complaint documentation.

The following Inspection Protocols were used during this inspection:

Reporting and Complaints
Responsive Behaviours

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]
Resident #1 was admitted to the home a few years ago. The written plan of care for resident #1 was changed on a specific date in December, related to resident #1 leaving the home. Staff are to assist resident #1 in getting family involved in resident #1's daily care needs. During an interview with the inspector resident #1 stated they were leaving the home independently prior to the specific date in December 2013.
A review of the progress notes for resident #1 for December 2013 indicated the Power of Attorney (POA) for Personal Care for resident #1 is the resident's family member. Through interviews on January 23rd and 24th, 2014 with the Administrator, Director of Care, Resident Care & Information Manager, Charge RN and the Unit RPN it was acknowledge that resident #1 and resident #1's POA for Personal Care were not given the opportunity to discuss with the home resident #1's ability to leave the home unattended prior to the plan of care being changed. [s. 6. (5)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward to the Director written complaints concerning the care of a resident or the operation of the long-term care home.
On a specific date in December 2013 the Director of Care received a letter of complaint concerning the care of a resident. On a specific date in December 2013 the same letter of complaint was received by the Administrator.
A review of the home's policy # ADM-V11-035, titled Complaints- Resident/Family dated July 2012 indicated that "Each written complaint concerning care of a resident or operation of the home with any supporting documentation (including results of investigation) is forwarded to the Ministry of Health and Long-Term Care".
During an interview with the inspector on January 23, 2014 the Administrator and Director of Care acknowledged they were unaware that the home is required to forward a written complaint concerning the care of a resident or the operation of the long-term care home to the Director. [s. 22. (1)]

WN #3: 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,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s 101.(2) (a) (b) (c) (d) (e) (f) the home was unable to provide the inspector documentation to support (a) the nature of each verbal or written complaint, (b) the date the complaint was received, (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, (d) the final resolution , if any , (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant. [s.101. (2)]
The Director of Care received a written complaint concerning resident #1 on a specific date in December 2013. The Administrator received the same written complaint on a specific date in December 2013. There is no documented record indicating the type of action taken to resolve the complaint, date of action, and time frames for actions to be taken and any follow-up required, the final resolution, dates any responses was made to the complainant and a description of the response and any response made by the complainant. [s. 101. (2)]

Issued on this 28th day of January, 2014

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

RENA BOWEN #549