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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2016	2016_346133_0006	019019-15	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

JESSICA LAPENSEE (133)

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): February 12th, 2016

This Critical Incident System inspection is related to a critical incident report that the home submitted to the Ministry of Health and Long Term Care, related to the loss of elevator service to the third floor on July 22nd, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator and a maintenance worker.

The Inspector reviewed the home's Emergency Services Manual with a focus on locating a plan that provided for dealing with the loss of elevator service.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (2) Every licensee of a long-term care home shall ensure that the emergency plans for the home are in writing. O. Reg. 79/10, s. 230 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 230 (2) in that the licensee failed to ensure that the emergency plans that provide for dealing with the loss of elevator service are in writing.

As per O. Reg. 79/10, s. 230 (4) 1. viii, the licensee shall ensure that the emergency plans for dealing with loss of one or more essential services.

As per O. Reg. 79/10, s. 19 (1) c, essential services include elevators.

Critical Incident Report (CIR) #2818-000017-15 was submitted to the Ministry of Health and Long Term Care on July 22, 2015 by the home's Resident Care and Informatics Manager. As per the CIR, elevator #2 stopped working at 0720 hours on July 22nd, 2015 and elevator #1 had been out of service since July 16th, 2015, awaiting a replacement part. As a result, there was no elevator access to the third floor unit. Elevator #3 was functional, and it serves the second floor. As per the CIR, elevator #2 was operational again by 1100 hours, on July 22, 2015.

On February 12th, 2016, related to the malfunction of elevator #2 on July 22nd 2015, a maintenance worker, #101, explained to the Inspector that the elevator had taken itself out of service. The maintenance worker explained that this had occurred because the elevator doors had been physically prevented from closing a certain number of times. He explained that an elevator technician must reset the elevator after such an event.

On February 12th, 2016, the Inspector and the Administrator reviewed the information in the CIR and discussed how the home had responded to the loss of elevator service to the third floor on July 22, 2015. Dietary staff, for example, has used the stairs to transport food for the breakfast meal to the third floor. A sign was posted at the front entrance of the building to inform visitors of the elevator malfunction and limited access to the third floor. Provisions were made for the emergency transfer of residents from the third floor to the second floor, where there was elevator service, should the need arise.

Related to the question of emergency plans, the Administrator was unable to locate a written emergency plan that provided for dealing with the loss of elevator service. The Inspector reviewed the contents of the home's Emergency Services Manual, as provided by the Administrator, and did not find a written emergency plan that provided for dealing with the loss of elevator service. By the end of the inspection day, the Administrator had produced a written emergency plan that provided for dealing with the loss of elevator service, titled "Procedure to Follow in Case of Loss of Elevator", with a "revised on" date of February 2016. [s. 230. (2)]

Issued on this 17th day of February, 2016

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

Original report signed by the inspector.