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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: August 29, 2023	
Inspection Number: 2023-1304-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: Villa Marconi Long Term Care Center	
Long Term Care Home and City: Villa Marconi, Ottawa	
Lead Inspector Linda Harkins (126)	**Inspector Digital Signature** Linda Harkins Digitally signed by Linda Harkins Date: 2023.08.31 09:36:56 -04'00'
Additional Inspector(s) Severn Brown (740785)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16, 17, 18, 21, 22, 23, 24, 2023

The following intake(s) were inspected:

- Intake: #00094674 - Proactive Compliance Inspection.

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control

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Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (1)

The licensee has failed to ensure that a Personal Support Worker (PSW) received training as required by FLTCA, 2021 s. 82.

Rationale and summary
During an interview regarding their training related to the prevention of abuse and neglect in the home and the PSW stated they never received training since starting their role at the home in 2021. The PSW further stated they did not receive training before performing their responsibilities on the residents' bill of rights, the long-term care home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, mandatory reporting to the Director, and whistleblower protections, as required by FLTCA, 2021 s. 82 (2).

A training record for the PSW was requested but the Director of Care (DOC) stated that no written training record was found for the PSW.

By not ensuring PSW was trained in the above areas as required, the PSW and residents are put at risk of harm due to the staff member lacking formal training.

Sources:
Interviews with a PSW and the DOC
[740785]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

i. The licensee has failed to ensure that a resident's care set out in the plan of care is provided to the resident as specified in the plan. Specifically, a resident's fall prevention strategies were not provided as set out in the plan of care.

Rationale and summary
A resident was observed during the course of the inspection in their bed. The resident's bed was not in its lowest position and no fall mat was observed beside the resident's bed. A PSW stated that the resident is supposed to have a fall mat beside the bed when they are in bed. The Assistant DOC confirmed that resident is to have a fall mat set up and their bed in the lowest position when they are in bed.

By not ensuring that the resident's fall prevention strategies were implemented as specified in the plan of care, the resident was placed at risk of sustaining an injury if they fall from bed.

Sources:
The resident's care plan;
Interviews with a PSW and the ADOC;
Observation of the resident.
[740785]

ii. The licensee has failed to ensure that a resident's care set out in the plan of care is provided to the resident as specified in the plan. Specifically, a resident's fall prevention strategies were not provided as set out in the plan of care.

Rationale and summary
A resident was observed during the course of the inspection in their bed. No fall mat was observed beside resident's bed. The resident's care plan states they are to have a fall mat set up beside their bed when they are in bed. The ADOC confirmed that resident is to have a fall mat set up when they are in bed.

By not ensuring that a resident's fall prevention strategies were implemented as specified in the plan of care, the resident was placed at risk of sustaining an injury if they fall from bed.

Sources:
Resident's care plan;
Interviews with the ADOC;
Observation of a resident.
[740785]

WRITTEN NOTIFICATION: Resident and family/caregiver experience survey: Action

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (3)

The licensee has failed to ensure that any reasonable effort to act on the results of the 2022 resident and family/caregiver experience survey to improve the home were made.

Rationale and summary
The 2022 resident and family/caregiver experience survey was conducted in 2022 however the Administrator, who was not the home's administrator at the time the survey was conducted, stated that no record could be found on any action being taken to improve the home based on the results of the survey.

By not ensuring that actions were taken regarding the results of the 2022 resident and family/caregiver experience survey, the licensee did not ensure that improvements were made to the home based on feedback provided by residents and/or their substitute decision regarding their experience with the home.

Sources:
Interview with the Administrator;
2022 resident and family/caregiver experience survey results.
[740785]

WRITTEN NOTIFICATION: Resident and family/caregiver experience survey: Advice

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee has failed to ensure that input was received for the 2022 resident and family/caregiver experience survey and an action report given from the results of the 2022 resident and family/caregiver experience survey to the Residents' and Family Councils.

Summary and rationale
A resident and family/caregiver experience survey was conducted by the home in 2022. A resident stated that no input from the Residents' Council was provided for the 2022 survey, and no action report based on the results of the 2022 survey was provided to the Residents' Council. The Family Council Chair stated that no input from the Family Council was provided for the 2022 survey, and no action report based on the results of the 2022 survey was provided to the Family Council. The Administrator stated that no record of input by or action report to the Residents' and Family Council could be found.

By not involving the residents' and family councils, they were not provided the opportunity to provide feedback on the survey or the results.

Sources:
Interviews with a resident, the Family Council Chair, and the Administrator;
Results of the 2022 resident and family/caregiver experience survey.
[740785]

WRITTEN NOTIFICATION: Resident and family/caregiver experience survey: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (a)

The licensee has failed to ensure the results of the 2022 resident and family/caregiver experience survey are made available to the Resident's and Family Council to seek their advice.

Rationale and summary
A resident stated that the Residents' Council was not provided the results of the 2022 resident and family/caregiver experience survey. The Family Council Chair stated that the results of the 2022 resident and family/caregiver experience were not made available to the Family Council. The Administrator stated that there was no record of any provision of the results to the Residents' and Family Council of the 2022 resident and family/caregiver experience survey.

By not providing the results of the 2022 resident and family/caregiver experience survey to the Residents' or Family Council to seek their advice, the licensee risked not implementing improvements to the home based on the results of the 2022 survey.

Sources:
Interview with a resident, the Family Council Chair, and the Administrator;
Results of the 2022 resident and family/caregiver experience survey.
[740785]

WRITTEN NOTIFICATION: Resident and family/caregiver experience survey: Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (b)

The licensee has failed to ensure that actions taken to improve the long-term care home and the care, services, programs and goods based on the results of the 2022 resident and family/caregiver experience survey were documented and made available to the Residents' and Family Councils.

Rationale and summary
The Administrator stated that no documentation of the actions based on the results of the 2022 resident and family/caregiver experience survey was found. A resident stated that the Residents' Council was not provided documentation the actions taken based the results of the 2022 resident and family/caregiver experience survey. The Family Council Chair stated the Family Council was not provided documentation the actions taken based the results of the 2022 resident and family/caregiver experience survey.

By not documenting any actions taken based on the results of the 2022 resident and family/caregiver experience survey or providing that documentation to the Residents' or Family Council, the licensee risked not properly implementing improvements to the home based on the results of the 2022 survey.

Sources
Interview with a resident, the Family Council Chair, and the Administrator;
Results of the 2022 resident and family/caregiver experience survey.
[740785]

WRITTEN NOTIFICATION: Cooling requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (3)

The licensee has failed to ensure that home's heat related illness prevention and management plan has been evaluated and updated, at a minimum, annually.

Rationale and summary
The home's heat related illness prevention and management plan was reviewed. The plan, titled Policy#: 05-04-08 Hot Weather Prevention and Illness Management plan was last revised in May 2021. The Administrator stated they were unable to find a more recently revised version of the policy than the one provided to the Inspector.

By not ensuring that the home's heat related illness prevention and management plan has been evaluated and updated annually, the licensee has not ensured that the policy has been updated with the most up to date best practices and legislative requirements related to resident care for the prevention and management of heat related illness.

Sources
Policy #05-04-08 Hot Weather Prevention and Illness Management last revised May 2021;
Interview with the Administrator.
[740785]

WRITTEN NOTIFICATION: Menu planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)

The licensee has failed to ensure that prior to being in effect, each menu cycle is approved for nutritional adequacy by the registered dietitian.

Rationale and Summary
Interview held with the Registered Dietitian (RD), who indicated that they have not approved any menu cycle in the last year.

Interview with the Dietary Manager (DM), who indicated that there is no documentation of a menu cycle reviewed and approved by the RD in the last year.

By not ensuring that the menu cycle was approved by the RD for nutritional adequacy, there is potential risk for residents to have a menu that does not meet their nutritional requirements.

Sources: Interviews with the DM and the RD and documentation review.
[126]

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)

The licensee has failed to ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented.

Rationale and Summary
Interview held with Dietary Manager DM), who indicated that the actual evaluation process of the menu cycle is not documented.

There was no written record of the menu planning evaluation available for the last year.

Sources; Interview with the DM and documentation.
[126]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)

The licensee has failed to ensure that the home's written plan for responding to infectious disease was

followed. Specifically, the licensee failed to ensure that a staff member complied with Policy INF 07-05-05 Universal Mask and Eye Protection Policy during COVID-19. Per O. Reg 246/22 s. 11 (1) (b), this policy must be complied with.

Summary and rationale
During the initial tour of the home for the inspection, a staff member was observed performing their duties in a unit, which was in a declared COVID-19 outbreak at the time of inspection, wearing a surgical mask only without any eye protection.

Per policy INF 07-05-05 last revised May 2023, in COVID-19 outbreak areas all staff, students, volunteers, and visitors must wear Universal eye protection and an N95 respirator. Signage posted at the entrance to the unit states that all staff, visitors, and volunteers must wear eye protection and an N95 respirator to enter the outbreak area.

By not ensuring that a staff member was wearing the personal protective equipment as required by the policy, the staff member increased the risk of disease transmission amongst residents and staff.

Sources

Observation of a staff member;
Policy INF 07-05-05 Universal Mask and Eye Protection during COVID-19.
[740785]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (e)

The licensee has failed to ensure that the program is evaluated and updated at least annually in accordance with the standards and protocol issued by the director.

The Director issued the “Infection prevention and Control (IPAC) Standard for Long- Term Care Homes” in April 2022.

Additional Requirement 5.2 of the IPAC Standard requires the licensee to ensure that policies and procedures are reviewed at least annually.

Rationale and Summary
The home's policy 04-01-10 Isolation Procedures was last revised January 1, 2022. The Administrator confirmed that the Isolation Procedures policy provided to the inspector, last revised January 1, 2022, was the most current version of the policy.

By not ensuring that the Isolation Procedures policy was evaluated annually, there is potential risk that the home does not implementing the most current legislative requirements.

Sources: Isolation Procedures policy #04-01-10 and interviews
[126]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)

The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Summary and Rationale
A Registered Practical Nurse (RPN) was observed preparing medication for a resident which included a controlled substance, Inspector #126 noticed that the controlled substances cards were kept in the bottom drawer of the medication cart and was not in a separate locked area.

Interview held with the RPN who indicated that they keep the controlled substances cards for the morning pass in the drawer, out of the separate locked area as they do not have to unlocked them each time.

The control substances cards for the morning pass, were not kept locked in a separate locked area could increase the risk for residents to access the controlled substances.

Source: Observation and interview with an RPN.
[126]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (1)

The licensee has failed to ensure that the written policy related to the drug destruction and disposal was complied with related to the insulin disposal.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a drug destruction and disposal policy and that needs to be complied with.

Rationale and summary
Two Registered Practical Nurses (RPNs) indicated that they were not aware of the policy related to the disposal of the insulin policy requirement.

Those RPNs did not comply with the policy “Drug destruction and disposal" dated November 2020 which requires nursing staff under Procedure 3. " Dispose of all surplus insulin (Vial/cartridges/prefilled pens) with a witness by the end of shift during which the insulin has become surplus. Log all disposed of insulin on the Drug and Disposal Log for Non -Narcotic/non-controlled medications and complete the required documentation." Both RPNs never disposed of surplus insulin with a witness and never used the drug disposal log.

Sources: Interviews with two RPNs and the drug destruction and disposal policy.
[126]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee has failed to ensure that a report on the continuous quality initiative (CQI) for the home was prepared within three months of the end of the 2022-2023 fiscal year.

Rationale and summary
The Administrator was unable to find or produce a CQI report for the home's CQI initiative upon request by the Inspector. Administrator spoke with members of Universal Care, the home's management contractor, who were unable to provide the Inspector with a CQI report. A resident stated no CQI report

was provided to the Residents' Council; similarly, the Family Council Chair stated that no CQI report was ever provided to the Family Council. A review of the home's website did not reveal a CQI report for the 2022-2023 fiscal year.

By not ensuring that a CQI report was produced for the 2022-2023 fiscal year, residents and their families/substitute decision makers are at risk of being unaware and uninformed of any continual improvement initiatives in the home.

Sources
Interviews with the Administrator, a resident, and the Family Council Chair;
Villa Marconi's Website.
[740785]

WRITTEN NOTIFICATION: Retraining

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)

The licensee has failed to ensure that annual retraining was done for donning and doffing for the purposes of subsection 82 (4) of the Act .

In reference to FLTCA, 2021, s. 82, (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

In reference to FLTCA, 2021, S. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 9. Infection prevention and control.

In reference to O. Reg 246/22, s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,(g) use of personal protective equipment including appropriate donning and doffing.

Rationale and Summary
A staff member was observed on the COVID Outbreak Unit, wearing Personal Protective Equipment (PPE) which included, N95 mask, face shield, gown and gloves on the Covid outbreak unit. As they exited the unit, the staff member did not remove the PPE and walked toward the elevator.

Interview held with the staff member, who indicated that they could not remember when they received the training on donning and doffing.

The Administrator and the Acting Environmental/ Housekeeping Manager, indicated that no record was found indicating that the staff member had received the retraining on donning and doffing.

By not removing the PPE when exiting the COVID Outbreak Unit and not receiving retraining on donning and doffing, there is potential risk of contamination between units.

Source: Observation, interviews with a staff member, the Administrator, and the Acting Environmental/ Housekeeping Manager.
[126]