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
Telephone: (877) 779-5559

Public Report

Report Issue Date: January 22, 2025

Inspection Number: 2024-1304-0006

Inspection Type:
Other
Complaint
Critical Incident
Follow-up

Licensee: Villa Marconi Long Term Care Center

Long Term Care Home and City: Villa Marconi, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite from December 18-20, 23-24, and 30-31, 2024 and January 6, 8-10, and 13, 2025.
The inspection occurred offsite on January 17, 2025.
The following intake(s) were inspected:

- Intake: #00131468 regarding a follow up to Compliance Order (CO) #001 from inspection #2024-1304-0005 related to communication and response system.
- Intake: #00131469 regarding a follow up to CO #002 from inspection #2024-1304-0005 related to the skin and wound care program.
- Intake: #00130351 regarding an incident of severe medical incident for a resident.
- Intake: #00132256 regarding an incident of failure/breakdown of major equipment.
- Intake: #00133284 regarding an allegation of resident to resident abuse.

- Intake: #00131299 regarding a complaint for care and support services provided to a resident.
- Intake: #00134645 regarding a complaint for care and support services for residents.
- Intake: #00135414 regarding a complaint for care and support services and equipment and devices used in the home.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1304-0005 related to O. Reg. 246/22, s. 55 (2) (b) (ii)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1304-0005 related to O. Reg. 246/22, s. 20 (a)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented on Point of Care (POC) documentation system. Specifically, documentation related to a resident's specified personal care task, were not documented a specified amount of occasions over two month period.

The Director of Care (DOC), Assistant DOC (ADOC) and a nursing staff member confirmed that care was provided to this resident as per their written plan of care, however, care was not documented on POC.

Sources: A resident 's POC task report for this two month period, interviews with the DOC, ADOC and nursing staff.

WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that walls and equipment were in a safe condition and a good state of repair.

Observations in one home area's shared resident rooms, accessible to residents had significant wall damages with sharp edges that two nursing staff members indicated these wall surfaces had been damaged for over a year. A maintenance staff member was aware of the status of these walls, but ongoing repairs have not been completed in over a year. Observations of resident bedrooms on another home area with significant wall and bathroom door damages preventing residents sharing these spaces to close their shared bathroom door when in use. A maintenance staff member indicated they were not aware of the wall or bathroom door damages in this home area as they were not identified in the unit maintenance logbook.

Another nursing staff member from a third home area, indicated on a specified date, an incident of malfunction of equipment occurred due to low power while in use with a resident. They attempted to replace the battery with another battery on their chargers in the unit storage area, but this battery was also without charge. Another staff member was called to assist and was able to locate a battery to assist the resident and indicated there must have been a problem with the battery or the charger that day. Images were taken of these batteries in this home area storage area on a specified date and five of the five batteries on these chargers had the letter F written on them. Maintenance staff member reported that the company for this equipment had conducted an audit of these batteries and indicated those that failed and required replacement with the letter F written on them. The Director of care (DOC) provided the inspector with this company battery audit from a specified date ten months earlier, that indicated this equipment battery had failed and required replacement now.

Sources: Observations of resident home areas, review of all home areas maintenance log books, the maintenance work log binder and reports from a

company charger and battery audit on a specified date, interviews with direct care staff, the DOC, a maintenance staff member and the interim Environmental Services Manager.

WRITTEN NOTIFICATION: Conditions of licence

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order #001 from inspection #2024-1304-0005, related to O. Reg. 246/22, s. 20 (a), served on a specified date, with an identified Compliance Due Date (CDD).

Specifically, the licensee did not comply with:

1) Develop and implement a documented procedure for all nursing staff to follow on every shift that will ensure:
a) That there are enough pagers for all staff who require one on the unit.
b) That documented action is taken with regards to any pagers that are not functional, such as a report to the maintenance department or use of a charging system.

2) Develop and implement a written procedure that will ensure that pagers are maintained in a good state of repair at all times, which includes scheduled preventative maintenance for all pagers to occur monthly, at a minimum.

3) Implement a documented system, with additional equipment as required, that provides for a system to ensure that registered nursing staff and unit supervisors are

alerted by the RSCRS of a call for assistance that has not been responded to within a reasonable amount of time. This procedure cannot rely on verbal notification from the nursing staff.

Review of the Pager Tracking Forms for one unit indicated specified dates when a specific pager was missing. On another unit, a second pager was missing on specified dates. During this inspection, a third pager had been missing for a specified period. As a result, there was not enough pagers for all staff members who require one on these units.

There was no written documentation on the Pager Tracking Form that a replacement was given on any of these recorded days or if action was taken. The documented procedure was not followed as required.

The written procedure titled "Call Bell Pagers Preventative Maintenance Schedule" requires documentation of all the following: an EVS Manager/designate to test each pager on the first week of each month, confirm that each pager is in good working order, ensure no outstanding maintenance requests, and any pagers that are not in good working order be replaced with the backup pager and to note it. There was no documentation on the form for a specified period as required.

Review of the Pager Tracking Form over a three month period, noted that there were pagers that are not in good working order or need to be replaced.

Review of the provided documentation and interviews with a roving executive director and a nursing consultant confirmed that no written procedure was created to ensure that there is an escalation process in place for the resident staff communication and response system (RSCRS) as required.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
NA

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

The licensee has failed to ensure that as part of the organized program for housekeeping under clause 19 (1) (a) of the Act, to ensure the developed procedures related to (a) cleaning of the home, including, (i) resident bedrooms furnishings, privacy curtains and contact surfaces were implemented.

Inspector observed visibly soiled window curtains in a resident's bedroom. A nursing staff member indicated these curtains have been soiled for several months including other resident bedrooms. A laundry staff member indicated they do not wash these curtains when visibly soiled, but they replace them with new curtains. The interim Environmental Services Manager (ESM) provided their policy that indicated there is a procedure for cleaning of window drapes annually or as required.

Sources: Observations of resident bedrooms and interviews with nursing and laundry staff as well as the interim ESM and review of Marquise policy and procedure.

WRITTEN NOTIFICATION: Maintenance services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee has failed to ensure that as part of the organized program of maintenance services under clause 19 (1) (c) of the Act, that there are schedules and procedures in place for routine, preventative and remedial maintenance.

A maintenance staff member indicated they did not have a regular maintenance schedule or procedure for guidance in maintenance tasks in the home. This maintenance staff reported following the home area maintenance log binders but staff are not using these consistently to report maintenance issues. The interim Environmental Services Manager (ESM) reported the home currently did not have any preventative maintenance schedule as items are fixed when broken and not included as part of a preventative maintenance program.

Sources: Observations in each home area, review of the maintenance log binders in each home area and the maintenance work binder, interviews with maintenance staff member and the interim ESM.

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that their written policy to manage a specific medical incident, was not implemented as all direct care staff did not receive training on the requirements of the licensee's policy and procedures as indicated in this policy.

Their pharmacy changed a medication product on a specified date in the home. On a specified date, a medical incident occurred for a resident and a registered nursing staff was not aware of this medication product or how to administer this to the resident. The Director of Care (DOC) indicated registered nursing staff were not educated on this medication product or how to provide this to a resident as required by the home's policy prior to this incident. Furthermore, another nursing staff indicated during this inspection, that they had not received this education to date.

Sources: Interviews with nursing staff and the DOC and review of the licensee's policy.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Remove slide latch locks on the outside of doors as identified in the grounds of this order.

2) Visually inspect and itemize all resident home areas for doors to ensure that no resident could be locked or trapped inside these rooms. This includes, but is not limited to, ensuring that there are no slide latch locks on the outside of doors in any home area.

3) Immediately remove any locks found as part of 1.

4) Continue to visually inspect all resident home area doors until the licensee is satisfied that the components of parts 1 and 2 have been fully complied with and keep a written record of 1, 2 and 3.

Grounds
The licensee has failed to ensure that the home area doors on a specified unit were a safe and secure environment for its residents.

During this inspection, slide latch locks were observed installed on the outside of specified doors in the common area of this home area. The slide latch locks were positioned approximately three quarters from the top of the door frame. A nursing staff member indicated these slide latch locks were not used but have been on these doors for a long time and several residents wander in this home area and could enter these rooms on their own. A maintenance staff member indicated they were installed several years ago to prevent residents from entering these rooms. The slide latch locks on the outside of these rooms in the common area of the home presented the risk of a resident being locked or trapped inside these rooms without

the ability to release the lock from the inside.

Sources: Observations of the specified unit and interviews with nursing and maintenance staff members.

This order must be complied with by February 3, 2025

COMPLIANCE ORDER CO #002 Elevators

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 13
Elevators
s. 13. Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Immediately develop and implement a written procedure to mitigate the risk of residents gaining unsupervised access, via elevators 1 and 2, to areas that should not be accessed by residents, such as the basement, service areas on all floors and serveries. All staff are to participate in the implementation of the procedure.

2) Immediately develop an auditing process that will be implemented by members of the home's leadership team, on every shift until item #3 is implemented, to ensure that the procedure required by item #1 remains in place and is effective at preventing residents from accessing areas that should not be accessed by

residents.

3) Equip elevators 1 and 2 with access controls inside the elevators to ensure that residents are restricted from accessing areas that are not to be accessed by residents such as basement, service areas on all floors, and serveries. Train all staff directly in use of the controls. Audit the controls daily, at least once per shift, for the first month following installation. Ensure to keep a written record of the audits with the name of the staff who conducted the audit, the procedure followed, the date and time that the audit was conducted.

4) Establish a written schedule and procedure for ongoing monitoring and preventative maintenance of access controls within the elevators to ensure the controls remain functional and effective, as a component of the required program of maintenance services as per Ontario Regulation 246/22, s. 96 (1) (b). This is to include documented weekly audits (after the first month of installation) with the name of the staff who conducted the audit, the procedure followed, the date and time that the audit was conducted.

5) Review this Compliance Order (CO) and the grounds that support this CO with all staff. Educate and train all staff on items #1, and #3. Keep a written record of the names of all the staff that are included in the review, education and training, name of the individual(s) who conducted the review, education and training as well as the dates that the education and training was completed.

Grounds
The licensee has failed to ensure that elevators 1 and 2 with access to the basement and service areas of the home are equipped to restrict resident access to areas that are not to be accessed by residents.

During this inspection, an inspector was able to access the basement as well as the service areas on floors 1, 2, and 3 through elevators 1 and 2 without needing an

access code or a key. The Director of Care (DOC) confirmed that the key access to the service areas on the elevators has been non-functional for approximately one year and has not been replaced. A maintenance staff member confirmed the same and confirmed that they have observed residents in the service areas previously. The DOC confirmed that residents can access elevators 1 and 2 from the main floor without needing to input an access code.

Sources: Observations, interviews with a maintenance staff member and the DOC.

This order must be complied with by April 16, 2025

COMPLIANCE ORDER CO #003 Availability of supplies

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Review the organized laundry program including processes related to: delivery schedules to home areas, methods of requesting additional linen supplies for each home area, development of linen quotas based on resident specific needs for each home area with direct care nursing staff, disposal and replacement of stained or damaged linen, and methods to laundering new linens from the vendor including

peri-cloths to prevent colour run when used for resident care.

2) Review the storage of clean linen supplies in each home area closet/linen carts, ensuring that the supplies are always readily available on each home area to meet the personal care needs of the residents on those units, for the beginning of every shift.

3) Review of processes in place to return soiled linen and peri-cloth linen bags to laundry department to prevent accumulation of soiled linen and odours in resident home areas.

4) Audit once a week of the availability of clean linen supplies on each home area prior to each shift and make changes based on the audits and the reviews required by 1), 2) until this order has been complied.

5) Documentation to support actions taken in regards to (1) through (4), and any other actions that the home determine necessary in order to ensure that linen supplies are readily available and used to meet the personal care needs of the residents.

Audits are to continue to support actions taken, until such time that this compliance order has been deemed to be complied by the MLTC.

Grounds
The licensee has failed to ensure that linen supplies were readily available at the home to meet the personal care needs of residents.

Observations of linen supply closets on a specified date during this inspection, identified a limited supply of specified linens. Interviews were conducted with nursing care staff and laundry staff throughout the home over the course of the inspection regarding the availability of linen supplies, who indicated routine

shortages of readily available linen required on home areas for the personal care needs of the residents, which resulted in use of other linen or paper towel products for the provision of personal care to residents. Overall, nursing care staff indicated they lost time for caring for residents due to the need to search for linen supplies in other home areas.

The Interim Environmental Services Manager (ESM) indicated upon arrival to the home on a specified date, they conducted a linen audit, which resulted in a need to order specified linens from their vendor. The Interim ESM indicated new linen stock from their vendor was discovered for other linen needs in the home, that were not placed into the laundry process to be used for direct care for residents, until after they had entered the home.

Sources: Interviews with nursing staff, the Director of Care (DOC), the Assistant DOC, the Interim ESM, the Food services Manager (FSM), the Interim Administrator, and residents. Observations on each home area linen storage closets, several linen carts, several resident bedrooms, and the laundry department. Record review of the vendor order forms and policy and procedures for laundry program by Marquise Hospitality group.

This order must be complied with by February 28, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.