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
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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
Dec 16, 2014	2014_346133_0015	O-000839-14	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

JESSICA LAPENSEE (133)

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): November 14th, 18th and 19th, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, The Director of Care, the Environmental Services Manager, and nursing staff.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

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

3 WN(s)
2 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. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 21 in that the licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius (22 C).

On November 18th, 2014, the inspector used their thermometer to determine the temperature in the Gentle Care small dining room. At 5:05 pm, the temperature was at 20.7C. The Administrator was informed.

On November 19th, 2014, the Administrator demonstrated use of the homes air temperature monitoring instrument to the Inspector. Together, the Administrator and the Inspector monitored temperatures in the following identified areas. This was done between 12pm and 12:30pm.

Room # 106 – 20 C within the entrance to the bedroom, 21 C at the bed area within the bedroom, 21 C at the comfortable easy chair within the bedroom.

Room # 135 – 20 C within the entrance to the bedroom , 20 C at the bed area within the bedroom.

Room #136 – 21 C at the bed area within the bedroom. It was noted that the thermostat in the bedroom reflected a temperature below 20 C.

Hallway, at entrance to area in which rooms #Y122-Y139 are located – 21C.

#137 – 21 C at the bed area within the bedroom.

#126 – 20 C at the bed area within the bedroom.

#138 – 21 C at the bed area within the bedroom. It was noted that the thermostat in the resident's bedroom reflected a temperature of 20C. The indicator was exactly on the

20C/70F marker.

Following this process, the home called in their HVAC contractor. Problems were noted with the equipment that serves to heat the fresh air being brought into the resident's bedrooms. At the end of the day, on November 19th, 2014, the Environmental Services Manager reported that repairs and modifications had been made, and the air coming in to the bedrooms from the ceiling vents was now measuring at 22 – 23C. The resident bedrooms are primarily heated by hot water radiators, below the windows. The fresh air vents are above the windows. This issue was impacting on the radiators capacity to adequately heat the bedrooms.

The licensee has a history of non-compliance with maintaining the home at a minimum temperature of 22 degrees Celsius. On January 16th, 2014, the licensee was issued a Written Notification pursuant to O. Reg. 79/10, s. 21 (inspection report #2013_304133_0035). This was in relation to a complaint inspection, conducted on December 19, 20 and 27, 2013. [s. 21.]

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 with the requirement that the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
2. Evacuation of the home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency. O. Reg. 79/10, s. 230 (4).

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 230 (4) 2. in that the licensee has failed to ensure that the written emergency plan that provides for dealing with evacuation of the home includes a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.

As per O. Reg. 79/10, s. 230 (2)., the emergency plans for the home must be in writing.

On November 18, 2014, the Inspector obtained a copy of the home's emergency plan that deals with evacuation of the home, from the Administrator's Emergency Services manual. It is titled "Evacuation Due To Emergency", # ESM-GRN-05, effective date June 2014. This plan does not speak to, in any way, a system in the home to account for the

whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.

The Inspector reviewed all of the plans in the Administrator's Emergency Services manual and did not find one that spoke to the required system, as referenced above. [s. 230. (4) 2.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 230 (7) c. in that the licensee has failed to ensure that a planned evacuation of the home is conducted at least once every three years.

On November 14, 2014, the Director of Care explained to the Inspector that the home has never conducted a complete evacuation of the home. The DOC explained that the home does not practice vertical evacuation, only horizontal evacuation. The DOC explained that in May 2013, a planned zone evacuation was conducted on the 3rd floor, west to east, and on the complex care unit, to the 2nd floor. The complex care unit and the 2nd floor unit are on the same level. The DOC explained that a zone evacuation was being planned for two bedrooms on the 2nd floor, in December 2014. This zone evacuation was planned in collaboration with a fire safety officer from the City of Ottawa. The DOC stated to the Inspector that the home does not have the necessary equipment to conduct vertical evacuations via stairways, such as specialized transfer chairs and flip down ramps in the stairwells. The DOC stated that in the event of the need to conduct a total evacuation of the home, requiring vertical evacuation from the care units via the stairs, fire safety officers and other such emergency responders would most likely be on site and would assist with the process. The DOC acknowledged that such an evacuation would certainly require participation of the home's staff as well.

The Inspector notes that there are 3 distinct areas of the home which are served by an elevator. Given the layout of the building, in the event of the need to conduct a total evacuation, it is possible that one or more elevators could be used if those areas were not affected by the emergency.

On November 18, 2014, the Inspector reviewed the home's emergency plan that deals with evacuation. It is titled "Evacuation due to Emergency", #ESM-GRN-05, effective date June 2014. On page 3 of 3, in the "training" section, it is written "all home staff will practice a zone evacuation annually. Minimally, once a year on day or evening shifts, and at least every two years, conduct a planned evacuation of the home with participation from your local fire department". Overall, the policy covers: partial evacuation – horizontal

and vertical, total evacuation of the home, and external evacuation requiring relocation of staff and residents.

On November 18, 2014, the Inspector reviewed the home's approved Fire Safety Plan. This plan makes note of the possible need to conduct horizontal evacuations, vertical evacuations, total evacuations and external evacuations. Current agreements were noted to be in place for external evacuations sites.

On November 19, 2014, the Inspector reviewed the home's disaster plan. It is titled "Disaster Plan", #ESM-ORG-05, effective date June 2013. On page 1 of 1, in the "Preamble" section, it is written "minimally every three years a Total evacuation must be performed as part of disaster planning". On page 1 of 1, in the "Procedure" section, it is written that the Administrator or delegate will "ensure that a full mock evacuation is implemented once every three years".

The licensee has a history of non-compliance in the area of emergency plans. On January 16th, 2014, the licensee was issued a Written Notification pursuant to O. Reg. 79/10, s. 230 (inspection report #2013_304133_0035). This was in relation to a complaint inspection, conducted on December 19, 20 and 27, 2013. [s. 230. (7)]

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 with the requirement that written emergency plans that deal with evacuation of the home include a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency. A written plan of correction for achieving compliance with the requirement that a planned evacuation of the home is conducted at least once every three years is also required. These plans are, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s.9 (1) 2 in that the licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when not supervised by staff, in order to restrict unsupervised access to those areas by residents.

On Friday, November 14th, 2014, the Inspector arrived into the Phase 2, level 2, dining room. At 2:22pm, the Inspector could see from afar that the door leading into the servery was not fully closed. There were no staff in the area supervising the door. Upon closer examination, it was observed that there was a spoon inserted into the striker plate, which served to prevent the door from closing. As the Inspector was making a note about this, the Food Service Supervisor (FSS) and some dietary staff came into the kitchen, via the rear door of the P2 elevator. The FSS expressed frustration, and noted that it has been a recurring issue over the years. At 2:31pm, the Inspector met a Personal Support Worker, staff #S101, in the dining room. Staff # S101 acknowledged having placed the spoon in the striker plate and explained that they didn't have their servery door keys with them on that day. Staff #S101 explained that although they can access the servery by way of the rear elevator door, there are often residents and visitors in the elevator and they cannot move the snack cart around them due to the size of the elevator car. Staff #S101 acknowledged having put a spoon in the striker plate in the past, and explained that the spoon stays in place for the duration of the snack pass, about 45 minutes.

It is noted that on Monday, November 17th, all of the home's dining room servery doors were equipped with key pad locks, thereby eliminating the need for staff to use a key to access the servery from the dining room. [s. 9. (1) 2.]

Issued on this 16th day of December, 2014

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

Original report signed by the inspector.