



**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**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 27, 2017	2017_619550_0010	000012-17, 002472-17	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**

JOANNE HENRIE (550)

**Inspection Summary/Résumé de l'inspection**



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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): March 15, 16, 17, 20 and 21, 2017**

**This Complaint Inspection is related to a complaint regarding the administration of medication, staffing and Family Council**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), a family member and the President of the Family Council**

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

**Family Council**

**Medication**

**Nutrition and Hydration**

**Sufficient Staffing**

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

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director at the Ministry of Health and Long Term Care regarding skin treatment to resident #002.

On a specified date in 2016, resident #002 was diagnosed with a specific skin condition to a specific body part and was prescribed a specific treatment to be provided as per a specific schedule. During an interview, the resident's family member indicated to Inspector #550 the resident was not provided with this treatment as prescribed.

Inspector #550 reviewed the resident's Medication Administration Record (MAR) for a specific period of time in 2017 and the documentation in the progress notes. The inspector observed that there was no documentation indicating that the treatment had been provided to the resident on eleven specified dates in 2017. On March 21, 2017, during an interview, the DOC indicated to the inspector that he investigated the situation on a specific date as it had been brought to his attention. He indicated that his investigation and interviews with the involved registered staff members revealed that staff members were under the impression that the specific treatment was not available.

During an interview on March 21, 2017, RN #101 indicated to the inspector that on a specific date in 2017, she informed and showed registered staffs that the treatment was still available. On another specified date she was made aware that they had ran out of the treatment supply and she re-ordered it from the pharmacy. At that time, the pharmacy informed her that the specific treatment was on back-order from the supplier and that they were going to try to get it from other pharmacies. RN #101 indicated that the treatment was never delivered by the pharmacy and the resident passed away three days later. There were no notes documented in the resident's health care records indicating that the physician or the resident's family were made aware that the treatment was not available from the supplier.

As evidenced above, resident #002 was not administered the specified treatment to a specific body part on eleven specific dates in 2017, as prescribed. [s. 131. (2)]



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***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 to ensure that all drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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Issued on this 27th day of March, 2017

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

**Original report signed by the inspector.**