Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2020	2019_627138_0021	021288-19, 022861-19, 022863-19, 022865-19, 022870-19, 023152-19	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

PAULA MACDONALD (138)

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 6, 7, December 3, 4, 5, 9, 10, 11, 16, and 17, 2019.

The following intakes were inspected as part of this complaint inspection:
log #021288-19, #022863-19, #022861-19, #022870-19, and #023152-19 relating to air temperatures and,
log #022865-19 relating to air temperatures and medication.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), family members, the maintenance lead, personal support workers (PSWs), registered practical nurses (RPNs), and residents.

The inspector also reviewed a resident health care record, reviewed recorded air temperatures taken by the home, reviewed policies related to medication administration, reviewed specific staffing hours, and took air temperatures in the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Medication
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for resident #002 is provided to the resident as specified in the plan.

The plan of care for residents, as defined by the home, includes the electronic medication administration record (eMAR). The eMAR for resident #002 directs registered nursing staff to provide the resident with a particular medication at a specific time. The medication admin audit report was reviewed for an approximate six week period and it showed that the particular medication was recorded as given outside the acceptable time frame on four days. The Director of Care stated that they are aware that resident #002's particular medication is to be provided to the resident at a specific time and they are aware that the medication has been given outside of acceptable time frames.

Log #022865-19 [s. 6. (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 to ensure the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: 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 license failed to ensure that the home is maintained at a minimum of 22 degrees Celsius (°C).

The Ministry of Long-Term Care received complaints that the temperature in phase 2 of the home dropped below 22 °C starting on a specific date. Maintenance lead #109 stated that the temperatures did drop in phase 2 of the home starting on a specific date and continued to drop into the following day to 18-19 °C. The maintenance lead stated that they were informed by the home of concerns with dropping temperatures on both dates. The maintenance lead stated that they addressed the issue on the second date and temperatures in the home returned to 22 °C that day.

Administrator #101 confirmed an issue with the temperatures in the home but stated the issue was confined to phase 2, bedrooms and hallways only and that the issue has been resolved.

In addition to the above, the home's recent documentation of temperature recordings provided by the administrator show that some temperatures in the home were measured below 22 °C. Specifically, ten measurements were recorded at 21 °C.

As such, the licensee failed to ensure that the home is maintained at a minimum of 22 °C.

(Log 021288-19, 022861019, 022863-19, 022865-19, 022870-19, 023152-19) [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 to ensure the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.