Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 8, 9, 15, 20, 22, 23, 2011	2011_034117_0040	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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse (RN), to several Registered Practical Nurses (RPN), to several Personnal Support Workers (PSW), to the Restorative Care Coordinator, to a housekeeper, to a Psychogeriatric Outreach Services Registered Nurse from the Royal Ottawa Hospital and to a Nuevatech Senior Systems Consultant.

During the course of the inspection, the inspector(s) reviewed the health care records for two identified residents; observed a resident room; reviewed email correspondences for Administrator@villamarconi.com and DOC@villamarconi.com from September 1 to November 8, 2011; reviewed posted "EMAIL INFORMATION" memo to resident family members dated November 16, 2011; reviewed Administrator Report to Family Council held November 1, 2011 and December 6, 2011; reviewed email communication between Nuevatech and PRIMUS computer systems; and reviewed the LTC home's policies and procedures: #NM-II-S025 Substitute Decision Maker (SDM), # NM-II-H030 Hypnotics/Sedatives and #PHAR-I-10 Administration of PRN Medications by RPNS.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Medication

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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. On a specified day in July, 2011, an identified resident's attending physician prescribed a medication. The medication prescription form was faxed to the pharmacy service provider and signed off as being actionned by two RPNS that same day.

Three days later, the medication had not been received by the home. The medication prescription form was re-faxed to the home's pharmacy service provider. Medication Administration Records indicate that the prescribed medication was given to the identified resident later that day, in July, 2011.

The licensee failed to administer the identified resident's prescribed medication for three days in July 2011, as specified by the prescriber.

Issued on this 23rd day of December, 2011

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

Lyne Duchesne #117