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: March 27, 2025

Inspection Number: 2025-1304-0001

Inspection Type:
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 on the following date(s): March 5-7, 11-14, 17-21, 24, 25, 2025.

The following intakes were completed in this follow-up inspection:
• Intake: #00137821 was a Follow-up #2 to Compliance order (CO)#001 issued in inspection #2024-1304-0005, related to O. Reg. 246/22 s. 20 (a) with a compliance due date December 23, 2024 that was re-issued in inspection #2024-1304-0006.
• Intake: #00137822 was a Follow-up #1 to Compliance order (CO)#001 issued in inspection #2024-1304-0006, related to FLTCA, 2021 s. 5 with a compliance due date of February 3, 2025.
• Intake: #00137823 was a Follow-up #1 to Compliance order (CO)#003 issued in inspection #2024-1304-0006, related to O. Reg. 246/22 s. 48 with a compliance due date of February 28, 2025.

The following intakes were completed in this complaint inspection:
• Intake: #00141404 was related to concerns regarding resident care and support services of a resident.

• Intake: #00141767 was related to concerns regarding palliative care of a resident.

The following intake was completed in this Critical Incident (CI) inspection:
• Intake: #00142500 was related to an allegation of staff to resident physical abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1304-0005 related to O. Reg. 246/22, s. 20 (a)
Order #001 from Inspection #2024-1304-0006 related to FLTCA, 2021, s. 5
Order #003 from Inspection #2024-1304-0006 related to O. Reg. 246/22, s. 48

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care - Documentation

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 a resident's plan of care was documented as required.

Review of the resident's record in Point Click Care (PCC) indicated that there were significant number of days over a specified period of time where documentation related to this resident's provision of care was not completed. An interview with the Director of Care (DOC) confirmed that documentation by staff is required on all shifts for care provided to the residents.

Sources: Resident's health care records reviewed; interview with the DOC.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A-The licensee has failed to ensure that the plan of care for a resident was reviewed

and revised, when the resident's care needs changed.

Specifically, the resident had a significant health decline, that resulted in a change in their health care needs, which was not outlined or updated in the resident's written plan of care to notify direct care and registered nursing staff.

Sources: Resident's health care records reviewed; interview with the Interim Administrator and DOC.

B-The licensee has failed to ensure that another resident's plan of care was reviewed and revised, when the resident's care needs changed.

This resident returned to the home on a specified date, with an additional medical diagnosis and required changes in specified areas of their plan of care that were not reviewed or revised three days later.

Sources: Observations of this resident; review of this resident's health care records; interviews with Nursing staff.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that their skin and wound care program to promote skin integrity and provide effective skin and wound care interventions was implemented for a specified resident in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the home's skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, as well as provide effective skin and wound care interventions, was complied with.

Registered nursing staff did not comply with the home's skin and wound management program policies and procedures for this resident's wounds.

Specifically, the Skin and Wound Management Program document "Quality Management" indicated that Registered Nursing staff are knowledgeable in all components of the skin and wound management program, as well as knowledgeable in utilizing the electronic wound application for documenting wound assessments.

Six different registered nursing staff members completed five different skin assessments on this resident's new wounds over a period of 19 days.
-These assessments were not completed with all components of their required skin assessments or utilized their electronic wound application for documenting these wound assessments as per their skin and wound care program procedures.
-No registered nursing staff added this resident's wound in the home's Electronic Treatment Assessment Record (ETAR) for ongoing monitoring needs as required.
-No referral to any dietitian was completed as required by their skin and wound program requirements for any new wound.
-On a specified date, a registered nursing staff did not report changes in the status of the wounds to the DOC and/or ADOC as required.

Sources: Observation of this resident's wounds; interviews with three registered

nursing staff, the ADOC, the DOC, the Interim Administrator; review of this resident's health records and skin assessments, the Skin and Wound Care Program Quality Management procedures, Wound Assessment procedures, and the Newly Identified Wound Checklist.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement, any standard or protocol issued by the Director with respect to Infection Prevention And Control (IPAC).

A-In accordance with the Infection Prevention and Control (IPAC) Standard: 9.1 b, the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At a minimum, routine practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene.

On a specified date, three Personal Support Workers (PSWs) were observed after handling soiled food dishes in a meal service then proceeding to provide other residents food items from the servery to eat or moving another resident to another location without performing hand hygiene. On the same day, during the provision of care in two resident bedrooms, another PSW did not perform hand hygiene between residents as required.

B-In accordance with the Infection Prevention and Control (IPAC) Standard: 10.4 h, The Licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting; and i) Support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

On a specified date, a PSW indicated during an interview that they had not provided residents Alcohol-Based Hand Rub (ABHR) or any assistance with hand hygiene prior to a snack service.

Sources: Observations of a meal service; interviews with four PSW's and the IPAC lead.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

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

1.Educate all nursing staff and the home's management team on the licensee's policy to promote zero tolerance of abuse (Resident's Rights #P-10 for Abuse and Neglect policy), with emphasis on the need to immediately report their suspicion of

resident abuse or neglect, relative to their disciplines.

2.Educate all registered nursing staff and the home's management team on the licensee's Continuous Quality Improvement policy for Client Service Reporting (CSR) #LGM-I10, with emphasis on when these forms are completed, who can complete these forms and who these forms are submitted to for review.

3.Educate all registered nursing staff and the home's management team on the importance of review of specified injuries identified in their skin and wound program, as well as policy in #1 and #2, when a resident has suffered harm or risk of harm due to potential improper or incompetent treatment, care, or other and that these incidents are evaluated by the licensee's management team with documented remedial actions for these residents as required.

4.Complete an audit for a specified resident incident, who experienced an injury of unknown cause to determine when this injury was discovered, who discovered these injuries and if appropriate actions with regards to the home's policies listed in #1 and #2 of this Compliance Order (CO) were followed. Document this audit for this resident's incident and document what corrective actions were taken.

5.Complete an audit for two other residents, who experienced an injury for unknown cause, to determine when these injuries were initially discovered, who discovered the injuries and if appropriate actions with the home's policies listed in #1 and #2 of this CO were followed. Document these audits for these resident's incidents and document if corrective actions were taken as required.

6.Continue this audit process from the date this CO is issued, for any resident with a new onset of an injury of unknown cause, until this CO has been complied.

7.Maintain documentation of the education in #1, #2, #3, including all actions related to this education, including who provided this education and how, who received the

education, what was educated and what dates these education sessions were completed.

8.Keep a written record of anything required for this CO.

Grounds

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

On a specified date, a resident was identified as having an injury of unknown cause. The ADOC went to assess the resident's injury. During a meal service on this unit on this same date, three PSW's and a registered nursing staff heard this resident allege harm from a PSW staff member, but no staff member reported this allegation of staff to resident abuse to the ADOC.

In accordance with the licensee's abuse and neglect policy:
-When a staff member has reason to believe that a resident has suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the Home, and to the Director. The resident's statements of allegation of staff to resident abuse were not reported to the home's management team and as such, the home did not submit any critical incident report immediately to the Director.

-Every verbal complaint made to the home or a staff member concerning the care of a resident or operation of the Home is dealt with and documented in the CSR. A specified PSW reported an injury to this resident for unknown cause to a registered nursing staff as required and they reported this injury in their shift report for follow-up on the next shift. The Director of Care (DOC) indicated they did not have any documented Client Service Reporting (CSR) form completed for this incident of

resident injury for unknown cause as required.

-Upon discovering an incident of suspected or witnessed abuse, a staff member is to prepare a written report (Suspected Abuse/Neglect Report). No documented written reports of this incident or the resident's allegations of staff to resident abuse.

-The home will immediately investigate any allegations of harm or potential harm to a resident, including if caused by abuse or neglect, and will thereafter take all appropriate action. No investigation was documented or actions taken related to this injury for unknown cause or allegations of staff to resident physical abuse.

-The Executive Director /designate will immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence. No police force was informed of this allegation of staff to resident abuse made by a specified resident to three PSW's and one registered nursing staff during a meal service on the initial date the injury for unknown cause was identified.

-Conduct and document interviews. No documented interviews were conducted related to this resident's injury or allegation of staff to resident abuse.

-The report is to be provided to the Executive Director or the Vice-President of Operations, who is to make a final decision. No report was ever provided to the Executive Director or the Vice-President of Operations.

The interim administrator indicated to the inspector, they submitted a critical incident report to the Director for this allegation of staff to resident physical abuse for this resident, 19 days after the incident was identified and opened a CSR for their investigation process when the inspector brought gaps in their process to their attention. The interim administrator indicated a call was placed to the police force regarding this allegation of staff to resident abuse.

Sources: Review of the licensee's policies for Abuse and Neglect and Client Service Reporting (CSR) and a resident's health records; interviews with nursing staff, the ADOC, the DOC and the Interim Administrator; observation of this resident's injury images.

This order must be complied with by April 23, 2025

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

CO s. 20.(a) FUI #2 was completed and this order has been complied. Interim Administrator was informed of the re-inspection fee.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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.