

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: December 18, 2025

Inspection Number: 2025-1304-0007

Inspection Type:
Complaint

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): December 11, 12, 17, 18, 2025

The following intake(s) were inspected:

- Intake: #00163423 - complaint related to resident to resident physical abuse.

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Behaviours and altercations

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee had developed procedures and interventions to support residents who were at risk of harm or had experienced harm due to other residents' behaviours, including responsive behaviours. However, these procedures and interventions were not implemented to reduce the risk of altercations or potentially harmful interactions between residents.

On the specified date, a staff member assigned to provide one-to-one support was not directly observing the resident as required and became involved in an altercation with the resident involving a clothing protector.

Sources: Review of residents' health care records and interviews with staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

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The licensee became aware of an alleged incident of physical abuse involving one resident by another resident; however, the affected resident's substitute decision-maker was not notified within the required 12-hour timeframe following awareness of the incident, as confirmed by staff.

Sources: Review of the resident's health care records and interviews with staff.