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
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Ottawa, ON, K1S 3J4
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Public Report

Report Issue Date: January 23, 2026

Inspection Number: 2026-1304-0001

Inspection Type:
Complaint
Critical Incident

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): January 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 22, 2026.

The following intake was completed in this complaint inspection:

Intake: #00166093 related to concerns about plan of care, an allegation of neglect and frequent falls.

The following intake was completed in this Critical Incident Inspection:

Intake: #00165675/ CI: #2818-000029-25 related to an allegation of neglect of a resident related to delayed response times of communication system.

Intake: #00166109/ CI: #2818-000030-25 related to an allegation of improper/incompetent treatment of resident resulting in fall with injury.

Intake: #00167717/ CI: #2818-000001-26 -Licensee to Forward Complaint, concerns related to delayed response times of communication system.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident's written plan of care indicated that the resident required extensive assistance using a mobility aid with all transfers. Based on Inspector's observations and interviews with direct care staff, it was identified that staff were not given clear direction on resident's transfer needs and indicated that the resident was unable to utilize the mobility aid.

Inspector observed fall prevention interventions in place for a resident, however clear direction for the use of these interventions was not found in the resident's written plan of care.

Sources: Resident's plan of care, Inspector's observations, and interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

A resident's plan of care stated that they required extensive assistance for all transfers and personal care. On a specific date, a staff member did not provide care to the resident as set out in the plan of care, and as a result the resident sustained a fall with injury.

Sources: Resident's plan of care, home's investigation notes, Critical incident report submitted.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

On specified dates, the home received written complaints concerning the care of a

resident. These complaints were not forwarded to the Director.

Sources: Written complaints received by home, interview with management.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

On specified dates, new skin injuries of unknown cause were identified on a resident by their substitute decision maker (SDM). Concern that the injuries were related to improper or incompetent care was brought to the attention of the home. The home had reasonable grounds to suspect improper or incompetent treatment or care of a resident by staff, and this was not reported to the Director.

Sources: Resident's electronic clinical record, interview with management.

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to

the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

On specified dates, the home received written complaints alleging harm or risk of harm of a resident from resident's SDM. Upon review of the home's investigation notes, an investigation was not immediately initiated and was never fully completed, no documented response was provided to the complainant within 10 business days.

Sources: Written complaints submitted by resident's SDM, interview with management, home's Complaint process LGM 1-10, last reviewed April 11, 2025.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #006 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 prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 25 (1) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

1. How the home will ensure that front line staff know when and how to report allegations of abuse and neglect.
2. How the home will ensure that all staff who are required to report to the Director are aware of the definitions of abuse and neglect, what needs to be reported to Director, when they need to be reported and how to report to the Director.
3. How the home will ensure that any alleged, suspected or witnessed incident of abuse or neglect of a resident including complaints that allege abuse or neglect will be investigated immediately.
4. How the home will ensure that the complaint process is followed when a verbal or written complaint is received that alleges abuse or neglect.
5. How the home will ensure that a documented and complete investigation is completed for each allegation of abuse or neglect. This includes gathering relevant documents, conducting interviews, documenting interviews and reaching a decision.
6. How the home will ensure that the outcome of the investigation is communicated to the appropriate people and when required, a response letter with requirements outlined in legislation is provided to complainant.
7. How the home will ensure that all staff will remain in compliance with the home's abuse and neglect policy.
8. Any audits the home will develop and implement to ensure long term compliance with home's abuse and neglect policy.
9. How the home will ensure that staff know how and where to document every task completed and that records are kept.

Please submit the written plan for achieving compliance for inspection #2026-1304-0001 to LTC Homes Inspector, MLTC, by email by Feb 9, 2026.

Please ensure that the submitted written plan does not contain any Personal

Information (PI)/Personal Health Information (PHI).

Grounds

On a specified date, a resident reported an allegation of neglect related to delayed response times to the communication system to a specific staff member.

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. This allegation was not reported to the home's management team until the next day and as such, the home did not submit a critical incident report immediately to the Director.

-Upon discovering an incident of suspected or witnessed abuse, a staff member is to prepare a written report (Suspected Abuse/Neglect Report) and this is to be provided to Supervisor. The staff member did not prepare a written report with required information on that day.

-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 immediate investigation was documented or actions taken related to this allegation of neglect.

-Conduct and document interviews. No documented interviews were conducted related to resident's allegation of staff neglect until several weeks later.

Sources: Resident's clinical health record, home's investigation notes, interview with management and home's abuse and neglect policy P-10, last reviewed March 14, 2025.

On specified dates, new skin injuries with unknown cause were identified on a resident.

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 new skin injuries with unknown cause was not reported 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 Client Service Response (CSR). The home did not initiate a CSR for the verbal complaint made by resident's SDM related to the skin injuries of unknown cause.

-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 SDM's concerns were found.

-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 immediate investigation was documented, or actions taken related to this injury of unknown cause.

-Conduct and document interviews. No documented interviews were conducted.

-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.

On specified date a staff member did not follow a resident's plan of care and as a result the resident sustained a fall with injury.

In accordance with the licensee's abuse and neglect policy:

-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. After a resident sustained a fall with injury as a result of staff not following plan of care, an immediate investigation was not completed by the home.

-Conduct and document interviews. No documented interviews were conducted related to the allegations of improper/incompetent care of a resident.

-Communicate the outcome, the decision, including any follow-up or disciplinary action is to be communicated to the SDM. No documented conversation with SDM was found.

On specified dates, the home received written complaints concerning the improper care of a resident.

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 concerns of improper care of a resident was not reported to the Director.

-Every formal 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. No documented CSR was found.

-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 immediate investigation was documented, or actions taken related to the complaints received by home.

-Conduct and document interviews. No documented interviews were conducted.

Sources: Resident's clinical health record, home's investigation notes, CIR submitted, interview with management and home's abuse and neglect policy, P-10, last reviewed March 14. 2025.

This order must be complied with by March 23, 2026

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

FLTCA s. 25 (1)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP 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 AMP.

COMPLIANCE ORDER CO #002 Responsive behaviours

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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

The licensee shall:

A) For a specific resident, perform a written audit of resident's plan of care to ensure that the following are present.

- Written approaches to care, including screening protocols, assessments, reassessments and identification of behavioural triggers where possible.

- Written strategies and interventions are developed and implemented to prevent, minimize or respond to responsive behaviours.

- Resident behavior monitoring and internal reporting protocols are being completed.

- Referral of resident to specialized resources where required.

-Documentation of resident's responsive behaviours and resident's response to interventions are completed.

-Medication review where required.

Audit must include; staff member that conducted the audit, date the audit was completed, findings of the audit and any corrective actions that were taken.

B) Educate all registered staff and personal support workers on a specific unit on any changes that were made to resident's plan of care as a result of the above audit. For all education that was completed, keep records that include the contents reviewed, date and time of review, name of staff that provided education, and name of staff receiving education including their signatures of completion.

C) Educate all registered staff and personal support workers on specific unit on the expectation when managing any resident displaying responsive behaviours including but not limited to: (documentation of every incident in POC or PCC, assessments/reassessments, behaviour monitoring, updating plan of care with written strategies, medication management, identification of behavioural triggers, documentation of resident's response and any required referrals).

For all education that was completed, keep records that include the contents reviewed, date and time of review, name of staff that provided education, and name of staff receiving education including their signatures of completion.

D) Maintain a record of everything required under part A), part B) and part C) and retain all records until the MLTC has deemed that this order has been complied with.

Grounds

A resident demonstrated responsive behaviors towards staff during personal care,

and between two specific dates, new skin injuries were identified.

During the inspection, the Inspector observed or was made aware of multiple incidents of when the resident demonstrated responsive behaviours. A review of the resident clinical health record did not indicate that any actions were taken to respond to the needs of the resident, including behaviour monitoring, assessments/reassessments, documentation of incidents, identification of triggers, initiating interventions, documentation of resident's response to any interventions, or any specialized referrals being made.

Sources: Resident's electronic health record, home's investigation notes, Inspector's observations and interviews with staff.

This order must be complied with by March 23, 2026.

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.