



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

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

**Ministry of Health and Long-Term Care**  
Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

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**Ministère de la Santé et des Soins de  
longue durée**

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<b>Date(s) of inspection/Date de l'inspection</b> May 5, 2011	<b>Inspection No/ d'inspection</b> 2011-034117-0007	<b>Type of Inspection/Genre d'inspection</b> Critical Incident Log # O-000899
<b>Licensee/Titulaire</b>  Villa Marconi Long Term Care Center 1026 Baseline Rd Ottawa, ON K2C 0A6 Fax: 613-727-5145		
<b>Long-Term Care Home/Foyer de soins de longue durée</b>  Villa Marconi 1026 Baseline Rd Ottawa, ON K2C 0A6 Fax: 613-727-6205		
<b>Name of Inspector(s)/Nom de l'inspecteur(s)</b>  Lyne Duchesne    #117		
<b>Inspection Summary/Sommaire d'inspection</b>		



The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with the home's the, Director of Care, to a Registered Nurse, to a Registered Practical Nurse, to three Personal Support Workers and to an identified resident.

During the course of the inspection, the inspector reviewed an identified resident's health care record, reviewed the home's Resident Abuse policy #NM-II-R005 and the home's Abuse Prevention Program policy # ADM-VII-005.

The following Inspection Protocol was used during this inspection:

- Personal Support Services
- Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

2 WN  
1 VPC

## NON- COMPLIANCE / (Non-respectés)

### Definitions/Définitions

WN – Written Notifications/Avis écrit  
VPC – Voluntary Plan of Correction/Plan de redressement volontaire  
DR – Director Referral/Régisseur envoyé  
CO – Compliance Order/Ordres de conformité  
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

**WN #1:** The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

- (2) Every resident has the right to be protected from abuse.
- (4) Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. .

### Findings:

- An identified resident suffers from dementia and is known to have physically and verbally aggressive behaviours.



- In May 2011, the identified resident was brought to his / her room by the identified Personal Support Worker. The resident was soiled and required some personal care.
- The identified Personal Support Worker started to provide care to the resident by him/herself. The resident became verbally and physically aggressive during care.
- The identified Personal Support Worker was seen to slap the identified resident's face with an open palm by another Personal Support Worker who was at the resident's room entrance.

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**Additional Required Actions:**

**VPC #1** - 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 regarding the identified resident's rights are to be protected from abuse, to be implemented voluntarily.

**WN #2:** The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, 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.

**Findings:**

- An identified resident suffers from dementia and is known to have physically and verbally aggressive behaviours.
- The resident's plan of care identifies that all of the identified resident's personal care needs are to be done by two staff members at all times.
- In May 2011, the identified resident was brought to his / her room by and identified Personal Support Worker. The resident was soiled and required some personal care.
- The identified Personal Support Worker started to provide care to the resident by him/herself. The resident became verbally and physically aggressive during care.

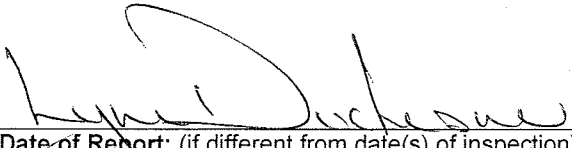
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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title:	Date:	 Date of Report: (if different from date(s) of inspection). May 6, 2011