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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 14, 2025
Original Report Issue Date: April 25, 2025
Inspection Number: 2025-1304-0002 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Villa Marconi Long Term Care Center
Long Term Care Home and City: Villa Marconi, Ottawa

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect a change for the issued legislative reference for written notification #002, issued April 25, 2025, from Ontario Regulation 246/22 s. 139 1. to Ontario Regulation 246/22 s. 138 (1) (a) (ii).

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23-25, 2025

The following intake(s) were inspected:

- Intake: #00137820 - Follow-up #: 1 - O. Reg. 246/22 - s. 13 Elevators in the home
- Intake: #00144957 - IL-0139075-AH/2818-000011-25 - Resident to resident physical abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1304-0006 related to O. Reg. 246/22 s. 13 related to elevators in the home.

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

Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices

AMENDED 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 (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.

The licensee has failed to ensure that the care set out in a resident's plan of care

was provided as set out in the plan. Specifically, the licensee failed to ensure that a staff member, who was assigned to break coverage for a resident's one-to-one PSW supervisor, was directly observing the resident when they had an altercation with another resident. Per the interviews with a PSW and the Director of Care (DOC), the resident must have one-to-one direct observation at all times when in any common area with residents around due to the resident's responsive behaviours.

Sources:
A resident's care plan;
One-to-one constant supervision staff education material for a resident;
A Registered Practical Nurse's documentation on an altercation between two residents on the date of the incident;
Interviews with two PSWs, and the DOC.

(A1)
The following non-compliance(s) has been amended: NC #002

WRITTEN NOTIFICATION: Safe storage of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs are stored in an area or medication cart that is secured and locked. Specifically, the licensee has failed to ensure that a medication cart was kept locked when not in use. During the inspection, the

inspector observed a medication cart on the third floor open without any staff members directly using the medication cart.

Sources:
Observation of medication cart on the third floor during the inspection.