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

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Public Report

Report Issue Date: June 24, 2025
Inspection Number: 2025-1514-0003
Inspection Type: Complaint Critical Incident
Licensee: Villa Colombo Homes for the Aged Inc.
Long Term Care Home and City: Villa Colombo Homes for the Aged, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 2-6, 9-13, 16-18, 20, 23-24, 2025

The inspection occurred offsite on the following date(s): June 20, 2025

The following Complaint intake(s) were inspected:
· Intake: #00146521 – Related to neglect, medication management, continence care

The following Critical Incident (CI) intake(s) were inspected:
· Intake: #00141834 [CI #3020-000037-25] – Related to staff-to-resident physical abuse resulting in injury
· Intake: #00144478 [CI #3020-000058-25, #2954-000016-25] – Related to neglect and improper wound
· Intake: #00144729 [CI #3020-000061-25] - Related to resident-to-resident sexual abuse
· Intake: #00145892 [CI #3020-000066-25], #00146159 [CI #3020-000067-25] – Related to a fall resulting in an injury
· Intake: #00146406 [CI #3020-000071-25], #00146819 [CI #3020-000073-25], #00147857 [CI #3020-000078-25] – Related to a disease outbreak

· Intake: #00147013 [CI #3020-000072-25], #00148486 [CI #3020-000082-25] – Related to diabetes management resulting in a hospital transfer

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

Skin and Wound Prevention and Management
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with respect and dignity by a Personal Support Worker (PSW).

A PSW instructed a resident to use a continence care product when the resident requested toileting assistance. The resident was in the immediate vicinity of other residents and was negatively impacted by the incident.

Sources: Observations, resident's clinical records and interviews with the resident, PSW and Nurse Manager (NM).

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

On two specific dates, the registered staff did not notify a specialty nurse, the Medical Doctor (MD), or the Nurse Practitioner (NP) of a worsening condition for a resident.

Sources: Resident's clinical records, interview with a NM.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 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 a treatment set out in the plan of care for a resident was provided to the resident as specified in the plan.

A Registered Practical Nurse (RPN) did not complete a daily scheduled treatment for a resident, however, they documented the treatment as completed.

Sources: Resident's clinical records, interviews with a RPN and NM.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff and others who provided direct care to two residents had convenient and immediate access to their plan of care.

A resident sexually abused a co-resident and an intervention to prevent a recurrence was verbally communicated to staff on the unit. Neither residents' care

plan included the intervention until a specific date, following a repeat incident.

Sources: Residents' clinical records, and interviews with a Behavioural Support Ontario (BSO) lead and NM.

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a co-resident was protected from sexual abuse by a resident.

Section 2 of the Ontario Regulation 246/22 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A resident had a history of sexually inappropriate behaviour towards a co-resident. The resident's care plan indicated an intervention to prevent this behaviour. Following a new incident of sexual abuse, it was identified that the intervention was not implemented as per the resident's plan of care.

Sources: CI report, residents' clinical records, home’s investigation notes, and interviews with a RPN, BSO lead and other staff.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident fell and sustained an injury, however, a post-fall assessment was not completed for the resident.

Sources: CI report, resident's clinical records, and interviews with a RPN and NM.

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (e)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

The licensee has failed to ensure that continence care products were not used as an alternative to providing toileting assistance to a resident.

A PSW instructed a resident to use a continence care product when the resident requested toileting assistance.

Sources: Observations, resident's clinical records, and interviews with the resident, a PSW and NM.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #008 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).

Specifically, the IPAC Standard for Long-Term Care Homes (revised September 2023), section 4.2 (e) indicated the IPAC lead's role included implementing changes to IPAC practices as needed to support the outbreak response.

Toronto Public Health (TPH) declared an infectious disease outbreak. On the outbreak management checklist form, TPH indicated as a general outbreak control measure that staff working in an outbreak area were to complete active screening prior to each shift.

The IPAC and Clinical Education Specialist (IPAC CES) confirmed a specific number of staff did not complete active screening prior to the start of their shift.

Sources: Confirmed Respiratory Outbreak Management Checklist, outbreak unit active screening log, and interview with the IPAC and CES and IPAC lead.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure three disease outbreaks were immediately reported to the Director.

On three separate occasions, when TPH declared infectious disease outbreaks, the home informed the Director at a later date.

Sources: CI reports, Confirmed Respiratory Outbreak Management Checklists and interview with the IPAC lead.

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure the written medication management policies and protocols were implemented when a medication incident occurred related to a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the medication management system were complied with.

1) A Registered Nurse (RN) administered a partial dose of a medication to a resident and documented it as having been completely administered. A NM and the home's medication management policy indicated that appropriate notations should be made in the resident's electronic medication administration record (eMAR) for medications when not administered completely.

2) A RN administered a partial dose of a medication to a resident. The RN indicated that they left the remaining medication in the resident's room. The medication was later found by a family member. The home's medication management policy indicated that medications were not to be left at the resident's bedside.

3) A RN left medication in a resident's room that was later found by a family member. The RN indicated that they did not complete a medication incident report form (MIRF). The home's medication management policy indicated that for a medication incident, a MIRF was required to be completed before the end of the shift.

4) A NM completed a MIRF for a medication incident involving a resident. The NM did not include contributing factors and root causes. The home's policy indicated these details needed to be included. The NM acknowleged that the contributing factors and root causes were omitted from the MIRF but should have been documented.

Sources: Resident's clinical records, policy Manual for MediSystem Serviced Homes, MIRF, email from the RN and interviews with the RN and NM.