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

Toronto District
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Public Report

Report Issue Date: August 21, 2025
Inspection Number: 2025-1514-0005
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): August 6-8, 11-15, 18-21, 2025

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00147298 – [CIS: 3020-000074-25]; intake: #00148971 – [CIS: 3020-000083-25]; intake: #00150190 – [CIS: 3020-000092-25]; intake: #00150336 – [CIS: 3020-000095-25] and intake: #00152609 – [CIS: 3020-000103-25] – Fall with injury
- Intake: #00152003 – [CIS: 3020-000101-25] – Improper care and treatment
- Intake: #00152874 – [CIS: 3020-000104-25] – Skin and wound management
- Intake: #00153279 – [CIS: 3020-000110-25] – Staff to resident physical abuse
- Intake: #00153315 – [CIS: 3020-000111-25] – Medication management

The following Complaint intake(s) were inspected:

- Intake: #00149237 – staff to resident neglect
- Intake: #00153181 – staff to resident physical abuse

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #001 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.

The licensee has failed to ensure that a complaint concerning the care of a resident was immediately forwarded to the Director.

The home became aware of the complaint regarding the care of a resident. This complaint was not forwarded to the Director.

Sources: Review of resident's clinical records and email correspondences with

complainant; and interview with former Nurse Manager (NM).

WRITTEN NOTIFICATION: Reporting certain matters to director

NC #002 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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care to a resident was immediately reported to the Director. This failure to report was acknowledged by the Unit Manager.

Sources: Critical incident reports #3020-000104-25 and #3020-000105-25, investigation notes; and interview with Unit Manager.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. B.
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:

3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee has failed to ensure that the response provided to a person who made a complaint related to a resident's care included an explanation of what the reasons the licensee believes the complaint was unfounded.

An investigation was conducted by the home and it was determined that the complaint regarding the care of a resident was unfounded. Former NM acknowledged that the complainant was not provided with a response that included an explanation for this belief.

Sources: Resident's clinical records and email correspondences with complainant; and interview with former NM.

WRITTEN NOTIFICATION: Medication management system

NC #004 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 comply with the written policies and protocols developed for the medication management system. 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 program were complied with.

Specifically, the home's policy indicated that upon resident admission, an accurate and complete medication history was obtained, and that all medications were written on the New Admission Order Form. Registered staff failed to ensure a medication was written on a resident's New Admission Order Form during admission, resulting in the medication not being ordered.

Sources: Resident's new admission order form and patient medical record; Manual for Medisystem Serviced Homes Policy (August 2024); and interviews with the RN and Nurse Manager.