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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: August 28, 2025
Inspection Number: 2025-1514-0004
Inspection Type: 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): July 30-31, 2025, and August 1, 5, 12-13, 18-21, 28, 2025

The inspection occurred offsite on the following date(s): August 22, 25-26, 2025

The following intake(s) were inspected:

- Intake: #00153920 - Critical Incident (CI) #3020-000113-25 - Resident to resident physical abuse resulting in injuries and hospitalization

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

Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Plan of care

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

1. Create a case study scenario of the incident between resident #001 and resident #002.

2. Conduct an in-person review of the case study with the home's Personal Support Workers, Registered Practical Nurses, and Registered Nurses, on a specific floor of a home area, and the Behavioural Support Ontario Lead.

3. In the review, discuss the steps that the staff should take in response to resident-to-resident altercation, including but not limited to interventions identified in residents' care plans, actions to take to prevent occurrence, actions the home could have taken but did not, and any other recommendations.

4. Maintain the records of the above discussions, including the content of the case study, content of the review, date of the review, name of staff who provided the review, and staff signed attendance.

Grounds

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #002 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Resident #002 had a history of responsive behaviours. On two separate dates, resident #002 entered resident #001's room and was difficult to redirect, with resident #002 exhibiting a responsive behaviour towards resident #002 on one of those dates. On both dates, no referral or collaboration occurred between the team and the Behavioural Support Ontario (BSO) Lead for resident #002's responsive behaviour.

On a third date, two staff observed resident #002 ambulating with the use of a mobility

aid. However, resident #002's plan of care indicated that they ambulated independently. The staff did not collaborate with registered nursing staff about the use of the mobility aid even though they had never seen resident #001 using a mobility aid.

Later that shift, an altercation occurred between residents #001 and #002. Resident #002 was found with multiple injuries requiring hospitalization.

Failure to ensure that staff collaborated with each other in the assessment of resident #002's care related to their responsive behaviours had led to the staff's inability to develop and implement appropriate interventions to minimize the risk of altercations and potentially harmful interactions with resident #001.

Sources: Interviews with the home's staff and management, resident #001 and #002's clinical records, the home's investigation notes.

This order must be complied with by October 3, 2025

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.