

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: April 14, 2026

Inspection Number: 2026-1514-0003

Inspection Type:

Complaint
Critical Incident
Follow up

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): March 25-27, 30,-31, 2026 and April 1-2, 7-10, and 13-14, 2026.

The inspection occurred offsite on the following date(s): April 13, 2026.

The following intake was inspected in this Follow up inspection:

Intake: #00164143 - Follow-up Compliance Order (CO) #003 from 2025-1514-0007 related to falls prevention and management.

Intake: #00170918 -Follow-up (CO) #001 from 2026-1514-0002 related to medication management.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Intake: #00165456 (CIS #3020-000184-25 / #3020-000185-25) - was related to a resident's care and services.

Intake: #00165630 (CIS #3020-000186-25), #00167348 (CIS #3020-000003-26) were related to abuse.

Intake: #00167695 (CIS #3020-000004-26), #00167836 (CIS #3020-000008-26) were related to falls prevention and management.

Intake: #00169881 (CIS #3020-000014-26) was related to unknown cause of injury to a resident.

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The following Complaint intake(s) was inspected:

Intake: #00172818 - related to multiple care concerns of a resident.

Previously Issued Compliance Order(s)

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

Order #003 from Inspection #2025-1514-0007 related to O. Reg. 246/22, s. 54 (1) inspected.

Order #001 from Inspection #2026-1514-0002 related to O. Reg. 246/22, s. 123 (1) inspected.

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

- Contenance Care
- Resident Care and Support Services
- Medication Management
- Food, Nutrition and Hydration
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards
- Pain Management
- Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident required a specific level of assistance for care. The level of assistance was not reflected in their written plan of care. The home updated the written plan of care to reflect the resident's current requirements.

Sources: Resident clinical records and interviews with relevant staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident's plan of care indicated contradicting interventions pertaining to diet type that required clarification from staff.

Sources: Resident clinical records and interviews with relevant staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

There was no collaboration with assessment from various staff in regards to a resident's care requirements.

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Sources: Resident clinical records, home's relevant policy, home's investigation notes; and interviews with relevant staff.

WRITTEN NOTIFICATION: Plan of care

NC #004 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.

Staff members did not collaborate with each other in the development and implementation of a component in a resident's care. As a result, an aspect of their care was not provided.

Sources: Resident clinical records, home's investigation notes; and interviews with relevant staff.

WRITTEN NOTIFICATION: Plan of care

NC #005 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.

i) A resident required a medical device to be applied at a specific time. However, the medical device was not applied as indicated.

Sources: Resident clinical records, home's investigation notes, and an interview with a staff.

ii) A resident's care plan was not followed in regards to the level of assistance required for specific care.

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Sources: Resident clinical records and an interview with a staff..

WRITTEN NOTIFICATION: Duty to protect

NC #006 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.

A staff member witnessed sexual abuse between two residents.

Sources: Critical incident report, resident's clinical records, home's relevant policy; and interviews with relevant staff.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 27 (2) 6.

24-hour admission care plan

s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

6. Known health conditions, including allergies, adverse drug reactions and other conditions of which the licensee should be aware upon admission, including interventions.

A resident's care plan did not include a specific care focus that was required during their admission to the home.

Sources: Resident's clinical records, home's assessment tool; and interviews with relevant staff.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 35 (2)

Nursing and personal support services

s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

A staff member did not follow the home's staffing plan when a unit was short staff.

Sources: Home's relevant policy, home's investigation notes, and interviews with relevant staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.

Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

4. Protocols for the referral of residents to specialized resources where required.

A resident demonstrated a responsive behavior towards another resident. However, the home did not send a referral to the most responsible team as required.

Sources: Resident clinical records, home's relevant policy; and interviews with relevant staff.

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

Dining and snack service

s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

A resident was not provided the appropriate level of assistance that was required during meals as indicated in their plan of care.

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Sources: Resident clinical records and interviews with relevant staff.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1. Create a case study scenario based on the incidents of unsafe transferring detailed in the grounds below and review it with all direct care staff on the units involved.
2. The case study must highlight the unsafe transfer technique that was used, the expected safe transfer practice, including the requirement to use a medical device when assisting a resident from the floor and the risks associated with not using the medical device.
3. Maintain records of the above content of the case study, content of the review, date of the review, names of the staff who provided the review and staff signed attendance.

Grounds

i) A staff member did not follow the required procedure when assisting a resident after a fall.

Sources: Resident's clinical records, home's investigation notes, home's relevant policy and interviews with relevant staff.

ii) A resident was transferred using an inappropriate technique.

Sources: Resident's clinical records, home's investigation notes; home's relevant policy; and interviews with relevant staff.

This order must be complied with by May 25, 2026



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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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

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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.



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