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: January 14, 2025
Inspection Number: 2025-1429-0001
Inspection Type: Complaint Critical Incident
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Villa Santa Maria Community, Woodbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7, 8, 9, 10, 13, 14, 2025

The following Complaint intake(s) were inspected:

- Intake: #00128947 related to improper care/neglect of a resident, outbreak management and housekeeping;
- Intakes: #00135077 and #00129489 related to an allegation of staff to resident abuse and;
- Intake: #00134121 related to a death of a resident.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00130213 related to a fall with injury;
- Intake: #00131329 related to a change in a resident's status and;
- Intake: #00135018 related to an allegation of staff to resident abuse.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 (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 a Registered Nurse (RN) collaborated with the Medical Doctor (MD) in the care of a resident following their death in the completion of the Resident Death Notice and subsequent notification to a provincial authority.

Sources: A resident's clinical records, Resident Death Notice, Procedure Upon Resident Death Policy, VIII-B-10.80, last revised September 2024 and; interviews with a RN and MD. [000715]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with by two Personal Support Workers (PSWs).

The home's abuse and neglect policy stated that staff had a duty to report immediately any suspected abuse of a resident that had occurred to the Executive Director or designate in charge of the community.

An allegation of staff to resident physical abuse was not reported immediately by a PSW and another PSW failed to report the incident to the home.

Sources: Review of Critical Incident, Prevention of Abuse & Neglect of a Resident Policy, #VII-G-10.00, Last Revised October 2023; and interviews with two PSWs. [665]