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: February 19, 2025

Inspection Number: 2025-1429-0002

Inspection Type:
Proactive Compliance Inspection

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): February 6-7, 10-14, 18-19, 2025

The following intake(s) were inspected:

- Intake: #00138618 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices

Pain 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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in two residents plan of care was documented.

a) A resident's daily care needs were not documented on multiple days. A Personal Support Worker (PSW) documented the care they provided to the resident, from the multiple days on a later date.

Sources: Resident's clinical records, interview with PSW.

Date Remedy Implemented: February 7, 2025

b) A resident's daily care needs and an activity of daily living (ADL) were not documented on a specific day. A PSW documented the care they provided to the

resident from that day that the documentation was not completed, on a later date.

Sources: Resident's clinical records, interview with PSW.

Date Remedy Implemented: February 11, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location. On February 6, 2025, it was observed that the home's policy to promote zero tolerance of abuse and neglect of residents was not posted in the home. The policy was posted in the home the same day by the Director of Care (DOC).

Sources: Observations on February 6, 2025; Interview with DOC.

Date Remedy Implemented: February 6, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a written record related to each evaluation under clause (3) (e) included the date that the summary of the changes were implemented. The home's evaluation of the staffing plan from February 21, 2024, did not include the dates that the summary of changes were implemented. The evaluation of the staffing plan was revised to include the dates that the summary of changes were implemented by the DOC on February 14, 2025.

Sources: Staffing plan evaluation of 2024; interviews with DOC.

Date Remedy Implemented: February 14, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home. On February 6, 2025, it was observed that the visitor policy was not posted in the home. The visitor policy was posted in the home the same day by the Director of Care.

Sources: Observations on February 6, 2025; Interview with DOC.

Date Remedy Implemented: February 6, 2025

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.

The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in the plan.

a) A resident's plan of care indicated that they required a level of assistance for an ADL. The resident was provided with a different level of assistance for the ADL by a PSW on multiple days.

Sources: Resident's clinical records, interviews with PSW; Registered Practical Nurse (RPN); and Associate Director of Care (ADOC).

b) The licensee has failed to ensure that the resident was provided with the appropriate beverage for their lunch on February 6, 2025, as specified in their nutritional plan of care.

Sources: Dining room observation, resident's health records, interviews with PSW; Dietary Aid; Registered Dietitian (RD).