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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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: June 5, 2025

Inspection Number: 2025-1429-0004

Inspection Type:
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): June 2 - 5, 2025

The following intake(s) were inspected:

- Intake: #00143180 - CIS # 2945-000012-25 - Outbreak
- Intake: #00143398 - CIS #2945-000013-25 - Fall of a resident resulting in injury.
- Intake: #00143467 - CIS # 2945-000014-25 - Alleged Neglect/improper care of a resident by staff.
- Intake: #00146043 - CIS # 2945-000019-25 - Fall of a resident resulting in injury.
- Intake: #00146171 - CIS # 2945-000020-25 - Outbreak

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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 (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

The licensee has failed to ensure that a resident's plan of care provided clear direction to direct care staff regarding bathing preferences and bathing equipment needed for safe bathing of a resident.
An incident occurred on a specific date were a resident was provided bathing care using specific equipment which resulted in an injury to the resident. The plan of care for that resident at the time of the incident indicated that their bathing preference was not followed.

Sources:
Resident health record review, LTCH investigation notes, and interview with 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 (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 a resident's plan of care related to bathing and assistance required was provided to the resident.
It was found that on a specific date a resident was receiving a shower by staff and the staff left the resident unattended in the shower room multiple times. The plan of care for the resident at the time of the incident indicated that they required a total assist of one staff for all bathing.

Sources:
Resident health record review, LTCH investigation notes, and interview with staff.