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: August 20, 2025
Inspection Number: 2025-1429-0006
Inspection Type: Complaint Critical Incident Follow up
Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Villa Santa Maria Community, Woodbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 11-15, 18-20, 2025
The inspection occurred offsite on the following date(s): August 14, 2025

The following intake(s) were inspected during this Critical Incident (CI) inspection:
• Intake: #00148579 [CI #2945-000023-25]- related to a communicable disease outbreak
• Intake: #00149802 [CI #2945-000024-25] – related to fall prevention and management
• Intake: #00151574 [CI #2945-000030-25] - related to fall prevention and management
• Intake: #00150394 [CI #2945-000026-25] – related to severe hypoglycemia

The following intake was completed during this complaint inspection:
• Intake: #00153430 – related to improper care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1429-0005 related to LTCHA, 2007 S.O. 2007, c.8, s. 73 (a)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards
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) (a)
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,
(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan of care for the use of a falls prevention and injury mitigation intervention for a resident. An observation revealed that the intervention was in place to prevent injuries in the event of fall, but it was not documented in the plan of care.

Another observation revealed the intervention was discontinued on a different date.

Sources: Observations, review of resident's care plan, and interviews with the Personal Support Worker (PSW), Registered Practical Nurse (RPN) and Associate Director of Care (ADOC).

Date Remedy Implemented: August 14, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when the resident's care needs had changed or care set out in the plan was no longer necessary.

The resident's care plan indicated they required a specific size of a device for transfers, however a different size was observed being used for the resident. Another review of the resident's care plan revealed that the care plan was updated to reflect the use of the appropriate size of the device.

Sources: Observations, review of resident's care plan, and interviews with the PSW, RPN and ADOC.

Date Remedy Implemented: August 14, 2025

WRITTEN NOTIFICATION: Duty Of Licensee To Comply With Plan

NC #003 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 a resident as specified in the plan related to nutrition and hydration. The resident's care plan and diet order directed staff to provide them with a specific fluid consistency. However, an observation during lunchtime revealed that the resident was given a different fluid consistency than what was indicated in their care plan.

Sources: Observations, review of resident's diet order, care plan and progress notes; and interviews with the RPN and Registered Dietitian (RD).

WRITTEN NOTIFICATION: Plan Of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed, and their plan of care was reviewed and revised when an safety intervention was not effective.

A specific device was noted as a falls prevention interventions in the resident's care plan. Staff indicated that the resident frequently refused the device, and that the intervention should have been reassessed and revised in their care plan.

Sources: Observations; resident’s clinical records, interviews with the PSW and RPN.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, a resident's symptoms indicating the presence of infection were monitored.

The resident developed a respiratory symptom, but further monitoring for symptoms of infection was not completed on multiple shifts. Infection Prevention and Control (IPAC) lead confirmed that staff should have documented symptom monitoring in the resident's progress notes during this time.

Sources: Resident's clinical records; and interview with the IPAC lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that a resident was isolated immediately when they presented with a respiratory symptom.

The resident was documented to exhibit a respiratory symptom, but isolation precautions were not initiated until two days later. IPAC lead confirmed the resident should have been placed on isolation precautions at the time of symptom onset.

Sources: Resident's clinical records; and interview with IPAC lead.