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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: October 20, 2025
Inspection Number: 2025-1429-0007
Inspection Type:
Complaint
Critical Incident

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): October 1, 2, 3, 6 -10, 14, 15, 20, 2025
The inspection occurred offsite on the following date(s): October 6, 16, 17, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
-Intake: #00152289 - CI #2945-000036-25 - related to Prevention of Abuse and Neglect
-Intake: #00152399 - CI #2945-000037-25 - related to Prevention of Abuse and Neglect
-Intake: #00153537 - CI #2945-000038-25 - related to Fall Prevention and Management
-Intake: #00153720 - CI #2945-000039-25 - related to Fall Prevention and Management
-Intake: #00155533 - CI #2945-000043-25 - related to Outbreak Management
-Intake: #00156332 - CI #2945-000048-25 - related to Fall Prevention and Management
-Intake: #00157595 - CI #2945-000050-25 - related to Resident Care and Support Services
-Intake: #00157825 - CI #2945-000051-25 - related to Fall Prevention and Management
-Intake: #00157846 - CI #2945-000052-25 - related to Outbreak Management

The following intake(s) were inspected in this Complaint inspection:
-Intake: #00155044 - related to Skin and Wound Care Management
-Intake: #00157155 - related to Skin and Wound Care Management

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

Skin and Wound Prevention and Management
Resident Care and Support Services
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 (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 a resident's plan of care was implemented when the indicated level of assistance required for bathing was not provided to the resident.

Sources: Review of the resident's care plan, documentation survey report; and interviews with a Personal Support Worker (PSW) and the Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 presence of a skin condition for a resident was documented.

During the six weeks following the onset of a new skin issue, PSWs failed to document the resident's skin impairment on multiple occasions.

Sources: Review of the resident's clinical record; interviews with the PSWs, Director of Care (DOC), Acting Executive Director (ED) and other staff.

WRITTEN NOTIFICATION: Duty to Protect

NC #003 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.

The licensee has failed to ensure that a resident was not neglected by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A PSW documented a resident's new skin issue, along with other PSWs on subsequent shifts for approximately two weeks. The PSWs stated they reported the skin issue to the registered staff, however there was no documentation of any assessments, interventions or follow-up actions during this period.

The lack of immediate action taken when a resident's wound was identified delayed implementation of appropriate interventions.

Sources: Review of the resident's progress notes, skin and wound evaluations, skin and wound treatment orders, electronic Treatment Assessment Record (TAR), home's policy titled "Skin and Wound Care Management Protocol" , and interviews with the ADOC Skin and Wound Lead, PSWs, DOC and other staff.

WRITTEN NOTIFICATION: General Requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented.

The licensee has failed to ensure that actions taken with respect to a resident under the Skin and Wound Care program, including assessments were documented.

i) A Registered Practical Nurse (RPN) stated that they applied a dressing to a resident's wound after they were informed by the PSWs of a new skin condition, but did not document their findings or application of the dressing in the resident's clinical records.

Sources: Review of the resident's clinical records and interview with the RPN.

ii) A registered staff suspected a wound infection and left a note in the Nurse Practitioner (NP) binder to assess. The NP stated that they responded to the registered staff's note related to the suspected infection the next day, however there was no documentation of what their assessment or actions entailed.

Sources: Review of the resident's clinical records and interview with the NP.

WRITTEN NOTIFICATION: Transferring and Positioning

Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the PSW used safe transferring techniques when assisting a resident.

The home's policy directs staff to remove a specific device prior to transferring a resident to a wheelchair. A PSW did not remove this device prior to transferring a resident to their wheelchair. As a result, the resident experienced a negative health outcome requiring medical intervention.

Sources: Review of home's investigation notes, home's policy titled "Transferring a Resident"; and interviews with the PSW, RPN, and ADOC .

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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (f) states that the licensee shall ensure that Routine Practices and Additional Precautions were followed

in the IPAC program. At minimum Additional Precautions shall include: Additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal.

A PSW was observed entering a resident's room that had signage for droplet and contact precautions without performing hand hygiene between doffing their surgical mask and donning a N95 mask. The PSW later exited resident's room and was observed doffing their eye protection first instead of removing their gloves as the initial step. Additionally, they obtained a new surgical mask prior to doffing their N95 mask.

Sources: Observations; interview with the PSW; policy Personal Protective Equipment - Attachments: Recommended steps for putting on and taking off PPE, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

COMPLIANCE ORDER CO #001 Required Programs

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Ensure that all registered nursing staff (including full time, part-time, casual) who work on an identified Home Area (HA), receive education on the home's skin and wound management program. The education must include:
-Registered staff's role and responsibilities in preventing, assessing, managing, reporting and documenting altered skin integrity
-A review of the pressure injury guidelines and treatment algorithm for each stage of pressure ulcers.
-When a referral is to be made to interdisciplinary team members, including but not

limited to the Skin and Wound Lead, with respect to a resident's altered skin integrity.
-How to identify altered skin integrity and how to report, respond within appropriate timelines, and document.
-How to complete assessment for wounds (type of wound, wound measurements, wound bed, exudate, peri wound, wound pain).
-How to obtain wound supplies, and steps to take when supplies are not available.

2. Ensure all personal support staff (including full time, part time, casual) who work on the identified HA receive education on the skin and wound management program. The education must include:
-Personal Support Workers (PSW)s role and responsibilities in preventing, assessing, managing, reporting and documenting altered skin integrity.

3. Keep a record at the LTC home of the education provided for item #1 and #2, including the staff members who received the education, the person(s) providing it, the content of the education, the date(s) it was provided and a signature of the staff member indicating that they completed the education.

Grounds

The licensee has failed to ensure that the skin and wound care program for the Long Term Care Home (LTCH) was implemented as required.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee was required to ensure that the home's skin and wound care program policies were complied with.

Specifically, the licensee's Skin and Wound Care Management policy directed registered staff to do the following:
-Complete weekly skin and wound assessment until skin alteration is closed/resolved.
-Treat altered skin integrity based on approved treatment recommendations.
-Skin and Wound Lead to conduct weekly skin and wound rounds to assess pressure injuries Stage II or greater, and to confirm the stage of all pressure injuries
-For Registered staff to respond to reports from Personal Support Workers (PSW)/Health Care Aides (HCA)s identifying any skin integrity alterations, and follow up with assessments as required
-Ensure completion of all sections of the wound assessment using the Point Click Care (PCC) Skin and Wound Application

The following information is in relation to a resident's altered skin integrity.

i) A review of the progress notes and skin and wound evaluations revealed there was no documentation to show that the Skin and Wound Lead was notified upon identification of a resident's skin alteration when it was indicated. The ADOC Skin and Wound Lead indicated that on when the new wound was identified, a referral should have been sent to the Skin and Wound Lead to conduct their assessment.

ii) The weekly skin and wound evaluations were not completed as per the home's policy.

A review of the skin and wound evaluations revealed that the resident's wound was not reassessed weekly by the registered staff using the skin and wound evaluation assessment when it was due on an identified date.

iii) The skin and wound evaluations were not fully completed and missed required components as per the home's policy.

A resident developed a pressure injury. The weekly skin and wound evaluations omitted information about the wound measurements as staff failed to assess and record the depth of the wound. Two RPNs both acknowledged that they never measured the depth of the wound during the weekly skin and wound evaluations. The ADOC Skin and Wound Lead acknowledged that the registered nursing staff did not consistently measure the depth of the pressure injury per the home's policy.

iv) The wound care dressing was not applied as ordered.

A resident was ordered to receive wound dressing changes every two days for their wound. However, a RPN reported that the resident's dressing was not changed on an identified date because the wound care supplies were not available. The Charge Registered Nurse (RN) and the ADOC Skin and Wound Lead both stated they were not notified of the insufficient supplies and that an alternate dressing should have been applied.

Failing to implement the home's skin and wound care program for a resident's wound increased the risk of wound deterioration.

Sources: Review of the resident's progress notes, skin and wound evaluations, treatment orders, electronic Treatment Assessment Record (eTAR), the home's policy titled "Skin and Wound Care Management Protocol", instruction course video titled " PCC Skin and Wound Application", home's protocol titled "Skin and Wound Management Guide" interviews with the ADOC Skin and Wound Lead, DOC, and other staff.

This order must be complied with by December 5, 2025

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.Provide re-training to identified registered staff, on the home’s procedures for recording symptoms indicating the presence of infection in residents on every shift and ensuring that immediate action is taken to reduce transmission and isolate residents.

2.Provide re-training to identified registered staff on the home’s expectations regarding accurate and timely documentation.

3.Maintain a written record of the training provided including the content, date, signature of attending staff, and the name of person(s) who provided the training.

4.Conduct audits on health records of all residents with signs and symptoms indicating the presence of infection on the identified resident HAs to ensure the home's procedures for recording symptoms indicating the presence of infection in residents on every shift were implemented and that immediate action was taken to reduce transmission and isolate residents. Conduct the audits twice a week on each home area, for a period of three weeks following the service of the order.

5.Maintain a written record of all audits conducted, include: the name of the auditor, the date and time of the audit, the resident's name and room number, the resident's signs and symptoms of infection for every shift, if the resident's signs and symptoms monitoring was recorded for all shifts, and any corrective actions taken if there was any resident monitoring/recording missing on any shift identified through the auditing process.

Grounds

The licensee has failed to ensure that the registered nursing staff took immediate action to reduce transmission and isolate four residents when they exhibited respiratory symptoms indicating the presence of an infection.
When four residents presented with symptoms of an infection, additional precautions were not initiated until the following day.
Infection Prevention and Control (IPAC) Leads confirmed that symptomatic residents were to be placed on additional precautions on the same shift of symptom onset. The DOC acknowledged that the registered staff failed to initiate additional precautions when the residents developed respiratory symptoms on their shifts, and failed to document the provision of care for these residents as per the home's procedures.
Failure to ensure that registered nursing staff took immediate action to isolate the residents when they exhibited infectious symptoms placed other residents and staff at risk for infection transmission.
Sources: Progress notes for four residents, home's policy "Additional Precautions, line lists for CI #2945-000043-25 and #2945-000052-25; and interviews with RPNs, IPAC Leads and the DOC.

This order must be complied with by December 5, 2025

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

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.