

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: April 28, 2026
Inspection Number: 2026-1429-0003
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): April 23 - 24, 27 - 28, 2026

The following intake(s) were inspected in the Critical Incident (CI) inspection

- Intake: #00168559 - [CI: #2945-000002-26- related to allegations of abuse
- Intake: #00174457 - [CI: #2945-000017-26] - related to a fall with injury

The following intake(s) were inspected in the Complaint Inspection:

- Intake: #00174453 related to frequent falls

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

- Prevention of Abuse and Neglect
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

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

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A resident was not treated with courtesy, respect and dignity, when they requested staff assistance on a specified date.

Sources: Interviews with staff, the Long Term Care Home's (LTCH) Abuse and Neglect Policy, LTCH's investigation notes, and staff Disciplinary Forms.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

A staff recommended the installation of a specific device to support a resident, however, the recommendation was not reviewed or implemented for a period of time.

Sources: Observations, review of the resident's clinical record, and interviews with staff.



Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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