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: February 25, 2025

Inspection Number: 2025-1452-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.

Long Term Care Home and City: Villa Colombo Seniors Centre (Vaughan), Vaughan

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 4, 6, 7, 10, 11, 12, 14, 19, 20, 21, 24, 25, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:

- Intake: #00132386 & #00133886 & #00139577- [Critical Incident System(CIS): 2969-000132-24 & 2969-000134-24 & 2969-000014-25]- Neglect
- Intake: #00132977 - [CIS: 2969-000133-24]- Fall with injury
- Intake: #00137069 - [CIS: 2969-000003-25]- Abuse
- Intake: #00137466 & #00138299 -[CIS: 2969-000005-25 & 2969-000008-25/2969-000009-25]- Improper care
- Intake: #00138661 -[CIS: 2969-000010-25] -Outbreak

The following complaint intakes were inspected:
- Intake: #00136572 - related to neglect, bathing, skin and wound, dealing with complaints, Residents' Bill of Rights, plan of care, availability of

supplies, and communication methods • Intake: #00138365 -related to unknown cause of bruising and neglect

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to quality care and self determination

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
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:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's right to be afforded privacy in caring for their personal needs was promoted and respected.

The inspector observed that staff did not close the resident's door or draw the curtains during their personal care.

Sources: Inspector's observation and interview with a Registered Nurse (RN).

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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;

(i) The licensee has failed to ensure that the planned care for a resident was included in their written plan of care related to their personal care.

Review of a resident's care plan indicated that their personal care instructions were not in the care plan.

Sources: A resident's care plan, and interview with the Director of Care (DOC).

(ii) The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident related to their monitoring interventions.

A monitoring intervention was initiated for a resident however, this intervention was not placed on the written plan of care until a later time.

Sources: Review of a resident's clinical records, interview with the DOC and other staff.

(iii) The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident related to their assistive device.

The inspector observed a resident in an assistive device. Occupational Therapist (OT) assessed the resident for this device and deemed this intervention to be appropriate based on the resident's needs, however this intervention was not placed on the care plan.

Sources: Inspector's observation, review of a resident's clinical record and care plan, interview with

OT.

WRITTEN NOTIFICATION: Plan of care

NC #003 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 provision of care set out in a resident's plan of care was documented.

A review of a resident's clinical records and staff interviews confirmed that a Personal Support Worker (PSW), who was not assigned to the resident, documented on behalf of another PSW.

The DOC stated that PSW's should documented on the care they provided to the assigned resident, and not to document on residents they did not provide care for.

Sources: Review of the resident's clinical record and interview with two PSWs and the DOC.

WRITTEN NOTIFICATION: Information and referral assistance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 17 (1)
Information and referral assistance
s. 17 (1) Every licensee of a long-term care home shall ensure that residents are provided with information and assistance in obtaining goods, services and equipment that are relevant to the residents' health care needs but are not provided by the licensee.

The licensee has failed to ensure that a resident was provided with assistance in obtaining specialist's services which were not provided by the licensee and were relevant to the resident's health care need.

The resident's progress notes indicated that a specialist's referral was to be initiated, however the

home was unable to provide evidence that the referral was initiated.

Sources: Review of the residence's progress notes, Long Term Care Home's (LTCH) investigation notes and interview with the DOC.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that an email complaint received concerning the care of a resident was immediately forwarded to the Director.

An email compliant was sent to the home on November 15, 2024, at 1520 hours, however the home submitted the complaint on November 18, 2024 at 1631 hours.

Sources: CIS # 2969-000132-24, and interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of
a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

(i) The licensee has failed to ensure that immediate report to the Director was completed when there were reasonable grounds to suspect improper care of a resident.

An email alleging improper care was sent to the home on January 17, 2025 at 1222 hours, however the home summitted the CIS on January 17, 2025 at 1638 hours.

Sources: CIS #2969-000005-25 and interview with the Administrator.

(ii) The licensee has failed to ensure that immediate report to the Director was completed when there were reasonable grounds to suspect improper care of a resident.

An email alleging improper care was sent to the home on January 26, 2025, at 1845 hours, however the home summitted the CIS on January 27, 2025
at 1641 hours.

Sources: CIS #2969-000008-25 and interview with the Administrator.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of abuse of a resident was immediately reported to the Director.

On January 13, 2025, a CIS report was submitted to the Director for an allegation of abuse of a resident. The resident was found to have multiple injuries.

The CIS report was submitted by the home after normal business hours. The home did not use the Ministry's method for after-hours emergency contact, therefore the allegation of abuse was not immediately reported to the Director.

Sources: Review of a resident's clinical health record, home's investigation file, CIS 2969-000003-25, and interview with the DOC.

WRITTEN NOTIFICATION: Obstruction, etc.

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 153 (b)
Obstruction, etc.
s. 153. Every person is guilty of an offence who,
(b) destroys or alters a record or other thing that has been demanded under clause 150 (1) (c); or

The licensee has failed to ensure that Infection Prevention and Control (IPAC) Manger did not alter a Personal Protective Equipment (PPE) audit.

The Dietary Aide stated that no one asked them to demonstrate PPE donning and doffing on February 3, 2025, at 0847 hours as they started their shift at 1030 hours.

Sources: PPE audit completed on February 3, 2025, at 0847 hours and interview with the Dietary Aide.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids, and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that a resident was provided with a mattress in accordance with manufacturer's instructions.

Maintenance Manager stated that they the resident's bed was 76 inches long and they provided the resident with 80-inch mattress.

Sources: Bed User manual from Carroll Healthcare, and interview with maintenance manager.

WRITTEN NOTIFICATION: Bathing

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident received a shower twice a week which was the method of their choice.

Review of Point of Care (POC) records indicated that a shower which was the method of choice was not provided to the resident.

Sources: Review of the resident's clinical records, and Interview with the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #011 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 staff used safe transferring techniques while assisting a resident.

A resident sustained a fall. The Registered Practical Nurse (RPN) assessed the resident and suspected an injury. The RPN and two other staff members manually lifted the resident. The resident was further assessed, transferred to hospital and diagnosed with a significant injury.

The home's Fall policy stated that the resident should not be moved if there is suspicion or evidence of injury that may require external treatment. The RPN stated, they suspected an injury upon assessment as the resident was guarding the area and was in pain.

The DOC stated since the resident had pain and suspected injury post-fall, the resident should not have been moved or manually transferred. The DOC acknowledged the staff did not follow the home's Fall policy.

Sources: Review of the resident's written plan of care, progress notes, homes investigation notes, CIS report #2969-000133-24, home's policy "Falls - Resident (LTC)" #16212555, last reviewed July 2024, interviews with the RPN , the DOC and other staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

(a) Conduct random audits for a resident to ensure the bathing intervention is provided for a period of three weeks following the service of this order.
(b) Conduct random audits for a resident to ensure 1:1 monitoring interventions are implemented and staff follow the 1:1 responsibilities and supervision of the resident, on day, evening and night shifts once a week, for a period of 3 weeks following the service of this order.
(c) Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

Grounds

(i) 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 their personal care.

The PSW stated that they did not comply with the plan of care during this resident's personal care.

Sources: Bed bath tip sheet for the resident, and interview with the PSW.

(ii) The licensee has failed to ensure that the care set out in the plan of care for monitoring was provided to a resident as specified in the plan.

A resident required an intervention for monitoring. The plan of care indicated that the resident was not to be left alone or unattended. The resident did not receive the monitoring intervention from staff. The resident was found alone and unattended by their family member. The RN and the DOC both acknowledged that the resident should not have been alone and therefore the plan of care was not followed.

Sources: Review of resident's clinical records and interview with the RN, the DOC and other staff

(iii) The licensee has failed to ensure that the care set out in the plan of care for monitoring was provided to a resident as specified in the plan.

A resident required an intervention for monitoring. The resident was found to be left unattended on multiple occasions by several staff members. The DOC acknowledged that the resident should not have been left unattended and their plan of care for monitoring was not followed.

Sources: Review of a resident's clinical records and interview with the DOC and other staff.

This order must be complied with by April 25, 2025

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

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.