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: June 3, 2025

Inspection Number: 2025-1452-0004

Inspection Type:
Complaint
Critical Incident
Follow up

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): May 5 - 9, 13 - 16, 20, 22, 23, 26 - 30, 2025 and June 2 and 3, 2025.
The inspection occurred offsite on the following date(s): May 13 and 30, 2025.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00139149 / CI #2969-000013-25 and Intake: #00142248 / CI #2969-000028-25 were related to abuse of a resident.
- Intake: #00140646 / CI #2969-000016-25, Intake: #00140745 / CI #2969-000018-25, Intake: #00142004 / CI #2969-000027-25, Intake: #00142670 / CI #2969-000030-25, Intake: #00142764 / CI #2969-000031-25 and Intake: #00144977 / CI #2969-000040-25 and 2969-000041-25, were related to neglect of a resident.
- Intake: #00144885 / CI #2969-000039-25 was related to improper care.

The following Complaint intake(s) were inspected:

- Intake: #00141599 was related to a complainant for safety of a resident.
- Intake: #00145073 was related to a complaint about improper transfer and neglect.

- Intake: #00145179 and Intake: #00142765 were related to complaint about multiple aspects of care.

The following Follow-up intake was inspected:

- Intake: #00140907 was related to Follow-up on previously issued Compliance Order under FLTCA, 2021 - s. 6 (7).

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1452-0001 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Continence Care
Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect

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:
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.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect was promoted, recognizing their dignity and individuality.

(i) A Personal Support Worker (PSW) transferred a resident from the spa room to their room with body parts exposed and certain products that should be concealed visible.

(ii) On two occasions, a PSW was observed throwing a towel on the floor during resident care after bathing, and subsequently using the same towel to provide personal care.

An interview with the Assistant Director of Care (ADOC) and the Director Of Care (DOC) confirmed that the resident should have been fully covered during transfers from the spa room to their room, and that staff were not to use towels that had been on the floor, in order to uphold the resident's dignity and ensure respectful care.

Sources: Video surveillance, and interviews with the PSWs, ADOC, and DOC.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
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:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that the right to proper care and services consistent with a resident's needs were respected.

A resident required a specific level of assistance for care including toileting and transfers. The resident had to wait for a period of time after pressing call bell to be assisted with care. Registered Nurses (RNs) and ADOC acknowledged that the care provided to the resident was not consistent with their needs.

Sources: Review of CI #2969-000040-25, video footage; resident's progress notes, internal investigation notes, policy titled 'Resident/Staff Communication & Response System'; and interviews with the RNs and ADOC.

WRITTEN NOTIFICATION: Resident Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 24.
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:
24. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

The licensee has failed to ensure that a resident's right not to be restrained was fully respected and promoted.

When a resident attempted to get up from their bed, a PSW told the resident to lie down several times and pushed them back into the bed which restricted their

movement.

Sources: Video footage, complaint letter, CI #2969-000028-25, and interview with the DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 for residents, was provided to them as specified in their plans.

(i) A resident's physician ordered for a device to be replaced with a new one at specific intervals. However, the resident was found with two devices on at the same time. The RPN acknowledged that they did not remove the old device when they applied a new one.

Sources: Resident's clinical records; interviews with RPN and the ADOC.

(ii) Another resident's care plan indicated that they required assistance with mobility and used a specialized assistive device for comfort and repositioning. On an identified date, the specialized device was not provided to the resident as directed in their care plan.

Sources: Resident's clinical records; interviews with the ADOC and other staff.

WRITTEN NOTIFICATION: Accommodation Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that a specific fixture in the home was safe and maintained in good repair.

When a PSW used the specified fixture, it dislodged and fell on a resident.

Sources: Complaint record, progress notes, and interviews with the PSW and Maintenance Manager.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #006 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.

In accordance with the definition identified in Ontario Regulation 246/22 section 7, "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes the inaction or a pattern of inaction that jeopardizes the health, safety or well-being.

A resident was ordered a specific treatment to prevent an identified health issue. However, this treatment was not administered multiple times, which increased the risk of the resident experiencing a negative health outcome.

Sources: Resident's clinical records; interviews with the ADOC and other staff.

WRITTEN NOTIFICATION: Mandatory Reporting

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 immediately report an allegation of verbal abuse of a resident to the Director.

In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Act, pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

A resident's Substitute Decision Maker (SDM) reported an allegation of abuse to a RPN. The RPN did not report the allegation to the Director.

Furthermore, the SDM also sent an email alleging abuse of the resident, however the allegation of abuse was not immediately reported to the Director.

Sources: Video footage, complaint letter, CI #2969-000028-25, Zero Tolerance to

Resident Abuse and Neglect, and interview with the DOC.

WRITTEN NOTIFICATION: Manufacturers' Instructions

NC #008 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 staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A resident was provided transfer assistance with a device in a way that did not follow the manufacturer's instructions. The staff identified that parts of the device were missing, which prevented them from using the device as the manufacturer directed.

Sources: Video surveillances, interviews with the PSWs, ADOC, and DOC, and manufacturer's guide.

WRITTEN NOTIFICATION: Incontinence Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that a resident received assistance from a PSW to manage and maintain continence.

A resident's care plan noted that they required a specific level of assistance for continence care. However, the PSW did not provide the required assistance to the resident during continence care.

Sources: Video footage, CI #2969-000028-25, and interview with the DOC.

WRITTEN NOTIFICATION: Snack Service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that a resident, who required assistance with eating, was not served a meal until someone was available to provide the required assistance.

The resident was served a meal at lunch and waited a period of time before a staff member provided assistance to the resident.

Sources: Resident's meal observation, clinical records, and interviews with the PSW, Food Service Manager, and DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #011 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.

The IPAC Standard for Long-Term Care Homes (LTCH), dated April 2022, revised September 2023, section 9.1 (b) indicated at minimum routine practices should include hand hygiene before and after resident contact.

Two PSWs did not perform hand hygiene before and after resident contact on multiple occasions while assisting residents with transfers and personal care, and before and after applying cream on the resident.

Sources: Video surveillance records; IPAC Standard for Long-Term Care Homes (revised September 2023); interviews with the PSWs, ADOC and DOC.

WRITTEN NOTIFICATION: Medication Management System

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the home's Reordering Medication Policy. A resident's prescribed medication was not available, because it was not reordered. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and protocols for the medication management system are developed and are complied with. Specifically, the Reordering Medication Policy stated that nurses were to re-order medication when they are not weekly batched supply medication. The ADOC acknowledged it was the nurse's responsibility to reorder the resident's medication as per the home's policy.

Sources: Resident's clinical records; Reordering Medications Policy, interviews with the ADOC and other staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident. Specifically, a resident was administered a medication multiple times, without the physician's order as acknowledged by the RPN, RN and DOC.

Sources: Resident's progress notes, physician's orders, policy titled 'Medication Administration - Oxygen LTC', and interview with the RPN, RN and DOC.

WRITTEN NOTIFICATION: Administration of Drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii) (A)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (2), or

The licensee has failed to ensure that PSWs did not administer a drug to a resident in the home unless they received training in the administration of drugs, in accordance with written policies and protocols developed under their Medication Management System.

A review of video footage and interviews with the PSW and ADOC confirmed that a PSW staff administered two prescribed medications on two occasions. DOC stated that the home did not have a policy related to PSWs administering medications to residents, and that the PSW staff had not received training in the administration of drugs.

Sources: Video surveillance; clinical records, interviews with the PSW, ADOC, and DOC.