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
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 14, 2025
Original Report Issue Date: August 8, 2025
Inspection Number: 2025-1452-0005 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.
Long Term Care Home and City: Villa Colombo Seniors Centre (Vaughan), Vaughan

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #002 has been amended to correct a staff identification error. The previously listed staff identification was updated, as both referred to the same individual. CO #001 is included in this report for reference only and has not been amended. Accordingly, its served date remains August 8, 2025.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4, 7-11, 14-18, 22, 24-31, 2025 and August 1, 8, 2025

The inspection occurred offsite on the following date(s): August 6, and 7, 2025

The following intake(s) were completed during this Critical Incident (CI)Inspection:

• Intake: #00145467 – [CI: 2969-000045-25] and Intake: #00149186 – [CI: 2969-000074-25] – were related to Skin and wound

• Intake: #00146822 – [CI: 2969-000051-25], Intake: #00150837 [CI: 2969-000083-25], and Intake: #00148896 – [CI: 2969-000072-25] – were related to communicable disease outbreak

• Intake: #00147085 – [CI: 2969-000053-25] – was related to Abuse and Neglect, transfer and repositioning, Infection Prevention and Control (IPAC), and nutrition and hydration

• Intake: #00147543 – [CI: 2969-000058-25] and Intake: #00147843 – [CI: 2969-000061-25] – were related to fall prevention and management

• Intake: #00147658 – [CI: 2969-000059-25], Intake: #00147834 – [CI: 2969-000062-25] and Intake: #00149673 – [CI: 2969-000077-25] – were related to resident care and services

• Intake: #00151604 – [CI: 2969-000092-25] and Intake: #0015186 [CI: 2969-000093-25] – were related to alleged abuse

The following intake(s) were completed during this complaint inspection:

• Intake: #00149791 – was related to water temperature, meal service, recreational activities, and care equipment

• Intake: #00149982 – was related to Improper care, alleged abuse/neglect, nutrition and hydration, restraints, medication, resident care and services, IPAC, and skin and wound

• Intake: #00151168 – was related to resident care and services, nutrition and hydration, air/water temperature, transfers and housekeeping

• Intake: #00151607 – was related to improper care and alleged abuse

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED 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 a resident's written plan of care included an identified fall prevention and management intervention.

A resident had a fall and experienced a negative health outcome. An identified fall intervention was not in the resident's written plan of care. However, the care plan was updated to include this intervention after it was brought to the home's attention.

Sources: CI #2969-000058-25, review of resident's written plan of care and interviews with Associate Director of Care (ADOC) and other staff.

Date Remedy Implemented: July 22, 2025

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) 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 was treated with courtesy and respect.

i) A Personal Support Worker (PSW) responded to multiple call bells when the resident rang, but turned them off without speaking to the resident and inquiring what assistance they required. The ADOC and the Behavioral Support Ontario (BSO) Lead both acknowledged that that the PSW should have spoken to the resident when responding to the call bells as per the home's policy.

Sources: Review of CI #2969-000077-25, home's internal investigation notes, video footage, the resident's progress notes, policy titled 'Resident/Staff Communication & Response System' with Policy ID #14146992 and last review date of December 2019, and interviews with the ADOC and the BSO Lead.

ii) When a resident needed toileting, a PSW directed them to use their continence product rather than providing them the required assistance as per their care plan. The Director of Care (DOC) acknowledged that the PSW failed to treat the resident with dignity and respect.

Sources: Review of CI #2969-000062-25, home's internal investigation notes, the resident's clinical records, and interviews with the DOC and a Registered Nurse (RN)
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WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
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:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that a resident's choice to refuse hand hygiene was respected.

An observation revealed that when a PSW offered alcohol-based hand rub (ABHR) to a resident, the resident showed signs of refusing the ABHR. The PSW continued to apply ABHR to the resident's hands and assisted with cleaning their hands while the resident continued to display signs of refusal.

Sources: Mealtime observation, and interview with the ADOC.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident 's written plan of care set out clear directions to staff.

A resident's care plan had a specific skin and wound prevention intervention. This intervention was not implemented by staff for several hours on an identified date. The PSWs reported that the care plan lacked clear directions as it did not specify the frequency to perform the intervention.

Sources: Video footage, the resident's care plan, and interviews with the PSWs.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A resident experienced an adverse event during a transfer with a specific device. The PSW stated they failed to report the incident to the Registered Practical Nurse (RPN), who confirmed no assessment was completed on the resident as a result.

Sources: Video footage, resident's progress notes and assessments, the home's Zero Lift Program policy (policy #18402433, last revised 06/2025), and interviews with the PSW, RPN and the DOC.

WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #006 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 two residents as specified in their plans.

i) On two occasions, records revealed that a RPN did not position the resident appropriately to receive the oral intake as specified in their care plan. The Registered Dietitian (RD) and the DOC confirmed that this did not comply with the resident's care plan and posed an aspiration risk.

Sources: Videos, resident's care plan, and interviews with the RPN, the RD and the DOC.

ii) The Critical Incident Report (CIR) showed that staff did not provide identified interventions for transfers and communication as specified the resident's plan of care on multiple occasions.

Sources: Review of CI #2969-000062-25, home's internal investigation notes, the resident's clinical records, and interviews with the RN and the PSW.

WRITTEN NOTIFICATION: Plan of Care

NC #007 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 a RPN documented the provision of care provided to a resident.

The resident had removed a specified device, and the RPN stated they provided care in response however, did not document this in the resident's progress notes.

Sources: Video footage, the resident's progress notes; and interviews with the RPN and the DOC.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #008 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 protect a resident from emotional abuse by the PSWs.

Section 2(1)(a) of the Ontario Regulation 246/22 defines emotional abuse as any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment, or infantilization performed by anyone other than a resident.

When two PSWs provided care to the resident, they used physical force when the resident showed signs of refusal. The resident showed signs they were negatively impacted by the PSWs actions.

Sources: The resident's clinical health records, video footage, and interviews with the PSWs and the ADOC.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that falls prevention and management equipment were readily available at the home for a resident.

The resident had a fall and experienced a negative health outcome. When a specific equipment was required for falls prevention and management, the RN was unable to implement it as it was not available. The ADOC acknowledged this intervention was not readily available at that time.

Sources: Critical Incident (CI) #2969-000061-25, the resident's progress notes, and interviews with the RN and the ADOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 2.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

The licensee has failed to comply with the home's skin and wound program when a PSW did not inform the registered staff of the resident's change in condition.

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

Specifically, the home's policy indicated PSWs are required to observe the skin when providing personal care and report any changes and observations to the registered nursing staff.

A resident showed signs of altered skin integrity on a specific part of their body, however the PSW who provided care did not report any change in the resident's condition. The ADOC stated that the home's investigation found the PSW should have noticed that the resident had an altered skin integrity and failed to document and report it to registered staff.

Sources: The homes policy #16217314 last revised June 2025 titled "Skin Care Program: Assessment and Care Planning (LTC)", the resident's progress notes, the home's investigation notes and an interview with the ADOC.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 2.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.

The licensee has failed to ensure that the home's bowel management program was implemented.

In accordance with O. Reg 246/22,11 (1) (b), the licensee was required to ensure a continence care and bowel management program to promote continence was implemented and was complied with.

Specifically, the Long-Term Care home (LTCH) did not comply with their policy "Bowel Management –Continence Screening" which required strategies to manage the specified health issue to be documented.

A resident experienced a specific health issue. Their care plan lacked treatments or interventions to prevent this health issue as confirmed by the DOC.

Sources: The resident's clinical records, LTCH's policy Bowel Management – Continence Screening, NUR (LTC) (Policy #14618990, last revised 09/2019), and interview with the DOC.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, the behavioural triggers for the resident were identified.

The resident had a history of specific responsive behaviours. The PSW stated that the resident often exhibited these responsive behaviours. The BSO Lead verified that the resident's responsive behaviour triggers were not identified.

Sources: The resident's clinical records, and interviews with the PSW and the BSO Lead.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when two residents demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

i) A resident was noted to have specific responsive behaviours, however no strategies were developed and implemented to respond to these behaviours. The DOC and the BSO Lead both acknowledged the same.

Sources: Review of CI #2969-000077-25, internal investigation notes, communication aid report, the resident's clinical records, and interviews with the DOC and the BSO Lead.

ii) A resident exhibited specific responsive behaviours during provision of care on multiple dates. A review of the resident's clinical records indicated that there were no interventions in place to respond to the resident's exhibited responsive behaviours. The BSO Lead confirmed that the resident had a history of the specified responsive behaviours.

Sources: Video footage, the resident's plan of care, progress notes; and interviews with the BSO Lead and the DOC.

iii) The resident had a history of specific responsive behaviours. A PSW stated that the resident often exhibited these behaviours. The BSO Lead verified no strategies and interventions were developed to prevent and manage the resident's responsive behaviours.

Sources: The resident's clinical records, and interviews with the PSW, and the BSO Lead.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the resident's responses to interventions were documented.

The resident had a history of specific responsive behaviours. A PSW stated that the resident often exhibited these behaviours. The BSO Lead verified that no actions were taken or documented to respond to their needs.

Sources: The resident's clinical records, and interviews with the PSW and the BSO Lead.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The licensee has failed to comply with the home's nutritional care and hydration program when nursing did not refer a resident's change in food intake to the RD.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies for the nutritional care and hydration program were complied with.

Specifically, the home's policy indicated a referral to the RD should be made when a resident's food was less than their usual pattern for three days or more.

The resident had less than their usual intake over several days, yet no referral was sent to the RD who confirmed the change in the resident's intake. The ADOC acknowledged the home did not follow their policy and make a referral to the RD.

Sources: The homes policy #17151173, last revised August 2023, titled "Dietitian Referral", the resident's progress notes, care plan and documentation survey report, and interviews with the RD and the ADOC.

WRITTEN NOTIFICATION: Housekeeping

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of

the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that cleaning and disinfection procedures were implemented when a RPN did not disinfect the blood pressure cuff between use on two residents during an observation. The RPN stated that it was disinfected once per shift. The Associate Director of IPAC confirmed that resident shared equipment should be disinfected between each resident use.

Sources: Observation, Cleaning and Disinfecting Policy (last reviewed May 2025); and interviews with the RPN and Associate Director of IPAC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #017 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 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact.

A PSW did not remove gloves or perform hand hygiene after providing the resident with continence care and before handling their personal item. The DOC confirmed that staff were required to wash their hand after performing continence care.

Sources: Video footage, Hand Hygiene Requirements Policy (Policy #17438758, last revised 02/2025), interview with the DOC, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

WRITTEN NOTIFICATION: Dealing with Complaints

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve a complaint related to a resident, including the date of the action, time frames for actions to be taken and any follow-

up action required.

A review of the home's complaint investigation notes revealed that there was no documented action taken, no date of the action, no specified time frames for actions to be taken, and no documented follow-up action in relation to the complaint received concerning the resident. The DOC confirmed the same.

Sources: Review of Complaint investigation notes, and interview with the DOC.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee has failed to ensure names of staff members who discovered the critical incidents were included in the CIR.

The CIRs sent to the Director regarding two residents' fall incidents did not include the name of the PSWs who discovered the residents. The ADOC acknowledged these names should have been included.

Sources: CIs #2969-000061-25 and #2969-000058-25 and interview with the ADOC.

WRITTEN NOTIFICATION: Administration of Drugs

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

The resident was prescribed a medication to be administered at a specified time daily. On an identified date, the medication was administered hours before it was due.

Sources: Review of the resident 's clinical records, the home's Medication Administration policy (Policy #18358820, last revised 06/2025), the home's investigation notes, and interview with the RPN.

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1.Provide education to identified PSWs on the home's safe transferring and positioning policy, specifically related to communication and collaboration during transfers and following the transferring and positioning directions in the plan of care. Maintain a record of the content of the education provided, including the date, signature of attending staff and the staff member who provided the education.

2. Conduct random audits of the PSWs mentioned in section 1, to observe for the appropriate use of transferring devices and techniques for residents who require mechanical lifts, for three weeks following receipt of this order, at a minimum of three times per week. Maintain a record of the audits, to include but not limited to, the staff member audited, audit dates, person(s) completing the audits, residents observed during the transfers, audit findings and any actions taken in response to the audit findings.

3. Retain all records until the MLTC has deemed that this order has been complied with.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting three residents.

i) While two staff were preparing a specific equipment for the resident's transfer, a

component of the equipment made contact with a part of the resident's body. Physiotherapist (PT) and the ADOC acknowledged that the PSWs performed an unsafe transfer. They were not working in coordination and should have communicated with each other during the transfer process.

Failure to assist the resident using safe transferring techniques resulted in a negative health outcome.

Sources: The resident's clinical records, video footage, and interviews with the PSW and the PT.

ii) A video revealed a resident was inadequately supported during a transfer using assistive equipment, which caused a specific part of their body to be improperly positioned. The DOC and PT confirmed the PSWs used unsafe transfer and positioning techniques.

As a result of improper transferring techniques, the resident was placed at risk of injury.

Sources: Video footage, and interviews with the PT and the DOC.

iii) A resident's care plan directed staff to use a specific device for transfers, however staff performed the transfer without using the device.

There was increased risk of harm to the resident when staff failed to use the specified device to support safe transferring of the resident.

Sources: Review of CI #2969-000062-25, home's internal investigation notes, the resident's clinical records, and interviews with the RN and the PSW .

This order must be complied with by September 30, 2025

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #022 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)]:

The licensee shall:
1.Provide re-training to identified RPNs 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.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.

3.Conduct audits on health records of all residents with signs and symptoms indicating the presence of infection on the identified Resident Home Area (RHA), 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 audit at least two times weekly, for four weeks.

4.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
i) The licensee has failed to ensure that the RPNs took immediate action to reduce transmission and isolate a resident when they presented with respiratory symptoms during a confirmed respiratory outbreak. The RPN confirmed they initiated additional precautions for the resident on the following day.

Additionally, the RPNs did not document any symptom monitoring for the resident on three shifts. The DOC confirmed the resident should have been placed in isolation at the time of symptom onset and that staff should have documented symptom monitoring in the resident's progress notes.

Failure to ensure that staff took immediate actions to isolate the resident when they exhibited respiratory symptoms put other residents and staff at risk of disease transmission.

Sources: Outbreak line list, the resident's progress notes; and interviews with the RPN and the DOC.

ii) During a COVID-19 outbreak, a resident developed respiratory symptoms

consistent with the outbreak case definition. The RPN did not add the resident to the line list or initiate contact/droplet precautions. The Associate Director of IPAC confirmed the RPN was responsible for these actions.

The failure to initiate appropriate isolation precautions and document respiratory symptoms for the resident increased the risk of infection transmission, potentially compromising the health and safety of other residents and staff.

Sources: The resident's progress notes, the home's Surveillance policy (policy #17438735, Last Revised 02/2025) and line-list, video footage, and interviews with the RPN and the Associate Director of IPAC.

This order must be complied with by September 30, 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

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.