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
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Public Report

Report Issue Date: October 8, 2025

Inspection Number: 2025-1514-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Villa Colombo Homes for the Aged Inc.

Long Term Care Home and City: Villa Colombo Homes for the Aged, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24-26, 29, October 1-3 and 6-8, 2025

The following intake(s) were inspected:

- Intake #00152741 - complaint related to multiple care concerns of a resident
- Intake: #00157447 - complaint related to care concerns of a resident
- Intake #00154310/Critical Incident (CI) #3020-000114-25 - related to injury of unknown cause
- Intake: #00157320/CIs #3020-000132-25/#3020-000133-25 - related to alleged staff to resident abuse and neglect
- Intake: #00158241/CI #3020-000138-25 - related to disease outbreak
- Intakes #00156270/CI #3020-000125-25; #00156560/CIs #3020-000126-25/#3020-000127-25; #00156733/CI #3020-000128-25; #00156745/CI #3020-000130-25; #00157397/CI #3020-000134-25; #00158783/CI #3020-000139-25; #00158853/CI #3020-000140-25 - were all related to fall incidents resulting to injury

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
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 (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.

The licensee has failed to ensure that staff collaborated in the implementation of a resident's plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. A staff was informed of a partially eaten item found in the unit. The staff acknowledged that the partially eaten item contained a resident's medications which they subsequently discarded without collaborating with the nurse.

Sources: CI Reports #3020-000132-25/#3020-000133-25; home's investigation notes and staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 a resident's fall prevention intervention was in place as specified in their plan. A resident was found in another resident's bed and was observed to have injuries of unknown cause. The home confirmed that the resident's plan of care related to fall intervention was not in place at the time of incident.

Sources: A resident's clinical records; home's investigations notes and staff interviews.

WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that written policies and protocols related to the medication management system was implemented for a resident with a specified diagnosis. On a specified date, the home's medication management policy was not followed when the medications were documented as administered at the same time of the resident's next scheduled dose of the same medications.

Sources: A resident's clinical records; home's policy titled "Medication Management," RC-16-01-07 (June 2025) and staff interviews.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 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. A staff was informed of a partially eaten item for which they acknowledged contained a resident's medications. The partially eaten item was subsequently discarded without the medications being administered to the resident.

Sources: CI Reports #3020-000132-25/#3020-000133-25; home's investigation notes and staff interviews.