

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: December 2, 2025

Inspection Number: 2025-1514-0007

Inspection Type:

Critical Incident
Follow up

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): November 17-21, 24-28, and December 2, 2025.

The inspection occurred offsite on the following date(s): December 1, 2025.

The following intake was inspected in this Follow Up inspection:

Intake: #00156490 - Follow-up Compliance Order (CO) #001 from 2025-1514-0004
related to plan of care

The following intakes were completed in this Critical Incident System (CIS) inspection:

Intake: #00159384 (CIS #3020-000141-25) was related to improper care

Intake: #00160047 (CIS #3020-000148-25) was related to injury of unknown cause

Intake: #00161289 (CIS #3020-000151-25) was related to allegation of abuse

Intakes: #00160035 (CIS #3020-000145-25), #00160122 (CIS #3020-000147-25) and #00160310 (CIS #3020-000149-25) were related to falls prevention and management

Intakes: #00160596 (CIS #3020-000150-25) and #00162210 (CIS #3020-000157-25) were related to infection prevention and control.

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1514-0004 related to FLTCA, 2021, s. 6 (4) (a)

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

- Contenance Care
- Resident Care and Support Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- 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 (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.

An intervention ordered for a resident was implemented six days after the scheduled date.

Sources: A resident's clinical records; and interviews with relevant staff.

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

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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.

A resident had a history of responsive behaviour associated with identified triggers. A staff member did not implement the intervention developed to respond to the identified trigger leading to an escalation of the behavior.

Sources: Resident's clinical records, home's investigation notes; and interviews with relevant staff.

WRITTEN NOTIFICATION: Notification Re Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (2)

Notification re incidents

s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

A resident's substitute decision-maker (SDM) was not notified of the result of an investigation into an allegation of physical abuse of the resident.

Sources: CIS report, Zero Tolerance of Resident Abuse & Neglect Policy (#RC-02-01-02, revised January 2022); and interview with relevant staff.

WRITTEN NOTIFICATION: Police Notification

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

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The home received a report alleging physical abuse of a resident by a staff member, which required police notification. The police service was not notified.

Sources: CIS report, Zero Tolerance of Resident Abuse & Neglect Policy (#RC-02-01-02, revised January 2022); and interview with relevant staff.

COMPLIANCE ORDER CO #001 Plan of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

The Licensee shall prepare, submit, and implement a plan to ensure that staff and others collaborated with each other in the implementation of a resident's care.

1. A root cause analysis related to an incident that led to the injury of a resident.
2. The plan should include how the home will address any identified gaps with staff involved to ensure staff competency by the Compliance Due Date (CDD).

Please submit the written plan for achieving compliance for inspection #2025-1514-0007 to LTC Homes Inspector, MLTC, by email by December 16, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

A device required by a resident was successfully applied by a staff member and functioned as intended. Later the same day, two other staff members removed the device and incorrectly reapplied it without consulting with the staff who initially applied it. This resulted in pain and injury to the resident, and the signs of injury were not reported to the

NP or physician

. As a result, the resident's health deteriorated.

The home's internal investigation concluded that two staff members provided incompetent care resulting from improper application of the device.

Sources

: Home's investigation notes, resident's clinical records; and interviews with relevant staff.

This order must be complied with by

January 14, 2026

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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**The inspector is ordering the licensee to comply with a Compliance Order
[FLTCA, 2021, s. 155 (1) (a)]:**

(a) Retrain one identified staff member regarding the use of Personal Protective Equipment (PPE) required for the care of residents on additional precautions; and two identified staff members on the appropriate sequence for donning and doffing PPE;

(b) Retrain seven identified staff members on hand hygiene practices in accordance with Public Health Ontario's just clean your hands (JCYH) program and include the four moments of hand hygiene;

(c) Audit hand hygiene practices of the
seven identified staff members
at a minimum four times a week for three weeks;

(d) Audit the PPE use of two identified staff members when in a room with residents on additional precautions at a minimum twice a week for three weeks, and include PPE donning and doffing sequence;

(e) Maintain a record of the aforementioned training, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training;

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(f) Maintain a record of the audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

Grounds

1) A staff member was observed exiting and entering resident home areas (RHAs) without performing hand hygiene. They interacted with multiple residents and their environment in two home areas (HA) and did not perform hand hygiene before and after each interaction.

Sources:

Observations; and a review of CIS report.

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2) The next day another staff member on another RHA was observed interacting with multiple residents and their environment while assisting in the dining room and did not perform hand hygiene before and after each resident/environment contact.

3) On the same day a staff member was observed assisting a resident on Droplet and Contact Precautions (DCP) without wearing the required PPE. After assisting the resident, the staff member did not doff the PPE used in the appropriate sequence upon exiting the resident's room.

4) A few days later, another staff exited another HA and did not perform hand hygiene. They returned to the unit and went into a resident's room without performing hand hygiene. The unit was on a confirmed outbreak. The staff was later observed not following the appropriate PPE donning sequence before entering the room of a resident on DCP in the HA.

5) On the same day a staff member entered the outbreak unit and went into multiple rooms without performing hand hygiene. They were observed providing assistance to two residents wearing the same disposable gloves and not performing hand hygiene before and after resident contact. They were later observed exiting and re-entering the outbreak unit without performing hand hygiene.

6) On the same day, another staff member exited a resident's room, interacted with another resident in the hallway and did not perform hand hygiene after exiting the room or before interacting with the resident outside the room. The staff member was later observed exiting the outbreak unit with another staff, neither of them performing hand hygiene.

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7) Two staff members were observed entering the outbreak unit on multiple occasions without performing hand hygiene, one of whom was observed exiting the unit without performing hand hygiene.

8) Later the same day, two other staff members entered the outbreak unit without performing hand hygiene.

Staff poor hand hygiene practices during a confirmed outbreak increased the risk of spreading infections in the home. In addition, staff failure to adhere to PPE requirements, including choosing the appropriate PPE and following the required donning/doffing sequence, may have compromised the long-term care home's infection control efforts.

Sources:

Observations; and a review of CIS report, Signages on RHAs, and public health communications with the home.

This order must be complied with by

January 14, 2026

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COMPLIANCE ORDER CO #003 Falls Prevention and Management

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Re-educate two identified staff members on care planned interventions to mitigate the risk of falls.
2. Audit care planned falls interventions for two residents once a day for one week and include individualized interventions per their plan of care.
3. Maintain a written record of the contents of the education and audits provided from part 1 and 2 of the order, the dates the education was provided, name of the attendees, their signatures and the individual(s) that provided the training.

Grounds

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, staff did not follow the home's policy titled, "Falls Prevention and Management" which directed staff to implement any strategies and interventions outlined in the residents' plan of care .

1) The home's investigation notes indicated that a staff member did not apply the required interventions for a resident as set out in their plan of care on a specified date, when the resident sustained a fall related injury. A few weeks after the incident, a staff member was observed not implementing the required interventions on two separate occasions.

Staff failure to implement care planned falls prevention interventions for a resident put them at risk of fall related injuries.

Sources: CIS report, Home's investigation notes, Falls Prevention and Management

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policy (#RC-15-01-01 revised March 2023); observations; and interviews with relevant staff.

2) A resident's written care plan indicated they required a specific intervention to mitigate the risk of falls. The resident had an unwitnessed fall with injury on a specific day when the intervention was not implemented. Staff failure to implement cared planned falls prevention interventions for a resident put them at risk of fall related injuries.

Sources: Review of CIS report, resident's clinical records, Falls Prevention and Management policy (#RC-15-01-01, revised March 2023) and home's investigation note; and interview with relevant staff.

This order must be complied with by February 27, 2026

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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

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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
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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.