

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: November 26, 2025

Inspection Number: 2025-1219-0004

Inspection Type:
Complaint

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: Fairview Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12-13, 17-20, 24-26, 2025

The following intakes were completed in this complaint inspection:

- Intake: #00159792 - related to falls prevention and management, continence care and bowel management, and responsive behaviours
- Intake: #00159897 - related to skin and wound care

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Continence Care
- Infection Prevention and Control
- 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

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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.

A staff member did not offer a piece of equipment for falls prevention and management to a resident that was a part of their plan of care.

Sources: Observations of the resident; Review of the resident's clinical records; Interviews with multiple staff members.

WRITTEN NOTIFICATION: Skin and wound care

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

A resident was known to have a wound. As per the home's policy, the site of the wound was to be cleaned and dressing changed at a specified frequency as prescribed by the physician. No orders for care of the wound site were in place for a period of time. A management staff member confirmed that there should have been an order in relation to the wound care during this period.

Sources: Review of the resident's clinical records; Multiple policies of the home related to skin and wound care; Interview with a staff member.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 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,

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reassessments and interventions and that the resident's responses to interventions are documented.

A resident displayed responsive behaviours on multiple dates over a period of time, but no assessments were completed. As a result, staff were not able to attempt interventions based on the resident's assessed needs. When interventions were attempted, staff did not document the resident's response to interventions on multiple dates.

Sources: Review of the resident's clinical records; Interviews with multiple staff.