

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: March 14, 2025 Inspection Number: 2025-1390-0002

Inspection Type:Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP **Long Term Care Home and City:** Fieldstone Commons Community, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 7, 10-14, 2025.

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

- Intake: #00133815 [CI #2906-000041-24] was related to alleged neglect.
- Intake: #00137550 [CI #2906-000002-25] was related to a fall with 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.



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

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 was provided with a falls prevention and management intervention when they had a fall that resulted in hospitalization and injury. The resident's plan of care directed staff to implement the intervention to mitigate the risk of falls and injury.

Sources: Critical Incident Report, resident's clinical records, and staff interviews.

[646]