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

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Public Report

Report Issue Date: September 22, 2025
Inspection Number: 2025-1390-0005
Inspection Type: Critical Incident
Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Fieldstone Commons Community, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 4 - 5, 8 - 9, 11 - 12, 16 - 19, 22, 2025.

The following critical incidents (CI) were inspected:
- Intake: #00151506 {CI #2906-000017-25} was related to fall of resident with injury
- Intake: #00154433 {CI #2906-000020-25} was related to fall of resident with injury
- Intake: #00157232 {CI #2906-000023-25} was related to disease outbreak
- Intake: #00157481 {CI #2906-000024-25} was related to disease outbreak.

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

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 (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 fall prevention interventions applied to a resident were included in their plan of care. A Registered Practical Nurse (RPN) indicated that the resident required close monitoring to mitigate the risk of falls, but this intervention was not included in the resident's plan of care.

Sources: The resident's clinical records, and interviews with a RPN and the Associate Director of Care (ADOC).

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Specifically, strategies were not clear to staff to support the resident with transferring resulting in the resident falling and injuring themselves. The resident's care plan directed staff to provide supervision and extensive assistance with one staff for transfer.

Sources: The resident's clinical records, and interviews with Personal Support Worker (PSW), RPN and ADOC.

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 a resident as specified in their plan related to assistance with ambulation and transferring.

A resident required one staff extensive assistance for transfer and supervision while using their assistive devise. A Registered Nurse (RN) did not assist the resident who transferred themselves. The resident sustained a fall that resulted in a significant change in their health status.

Sources: The resident's clinical records, interviews with RN and ADOC.

WRITTEN NOTIFICATION: Duty to Protect

NC #004 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 ensure that a resident was not neglected by staff.

Ontario Regulation (O. Reg) 246/22, section (s.) 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

After a fall, a RN did not thoroughly assess the resident for injury or address their pain. The resident made several complaints to the nurse and they were not addressed. It was confirmed that the resident had sustained serious injuries requiring medical attention.

The ADOC acknowledged that the RN should have completed a full assessment and provide treatment to the resident.

Sources: A Resident's clinical records and home's investigation notes, and interview with a RN, a RPN, PSWs, and the ADOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that the infection prevention and control lead implemented the hand hygiene program in accordance with the standard issued by the Director.

i). According to 10.1 b) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that the hand hygiene program includes access to hand hygiene agent, including 70-90% Alcohol-Based Hand Rub (ABHR).

A PSW used a product to clean a resident's that did not contain 70-90% ABHR. Infection Prevention and Control (IPAC) Lead stated that the staff should not have used that product to perform hand hygiene for residents.

ii). A PSW assisted a resident with hand hygiene with an expired ABHR. Infection Prevention and Control (IPAC) Lead acknowledged that the staff should not have used the expired ABHR to clean the resident's hands.

Sources: Observations of the inspector, interviews with PSW, and IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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).

The licensee has failed to ensure that all staff participated in the implementation of the home's Infection Prevention and Control (IPAC) Program when two staff members were observed not wearing personal protective equipment (PPE) when in contact with a resident who was on additional precautions.

A PSW and student PSW were observed providing personal care to the resident who was on additional precautions. Both staff and student were not wearing the required PPE.

The PSW then exited the resident's room and did not remove their dirty gloves and perform hand hygiene.

Sources: Observations on a resident home area, interviews with PSW and IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident was isolated immediately when they presented with symptoms.

The resident was documented to have respiratory symptoms, but isolation precautions were not initiated until two days later.

IPAC lead confirmed the resident should have been placed in isolation at the time of symptom onset.

Sources: Resident's clinical records; and interview with IPAC lead.