

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 21, 2025

Inspection Number: 2025-1390-0006

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 date(s): November 12 - 14, 17 - 21, 2025

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

- Intake: #00156712 [CI: 2906-000021-25], Intake: #00159865 [CI: 2906-000029-25], Intake: #00160884 [CI: 2906-000032-25], Intake: #00161270 [CI: 2906-000033-25] - related to fall of residents resulting in injury.

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

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) (a)

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,

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(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

The staff involved in a resident's care did not collaborate in the assessment of the resident so that their assessments were consistent with and complemented each other. A resident sustained a fall resulting in injury. According to two Personal Support Workers (PSW), at the time of the fall, the resident had an intervention in place which was not included in the resident's plan of care.

Sources: Resident's clinical records, and interviews with two PSW, and the Falls Lead.

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 care set out in the plan of care was not provided to a resident as specified in their plan. A resident's plan of care directed staff to place their device within reach of the resident. An observation showed the device was not within reach of the resident while the resident was in their room sitting in their wheelchair.

Sources: Observations made by the inspector; a review of the resident's plan of care; and interview with a PSW.

WRITTEN NOTIFICATION: Fall Prevention and Management

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

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).

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An intervention that was identified in a resident's written plan of care as a falls prevention strategy was not implemented.

An observation by the Inspector revealed that the intervention was not in place while the resident was sitting on their wheelchair. A PSW confirmed that the intervention was required to be in place while the resident was in their wheelchair.

Sources: Inspector's observation of resident's room, review of the resident's clinical records, interviews with a PSW and the Falls Lead.