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

Toronto District
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Public Report

Report Issue Date: July 28, 2025

Inspection Number: 2025-1402-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Norfinch Community, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-11, 14-17, 25, 28, 2025 and offsite on the following date(s): July 17, 2025

The following intake(s) were inspected:

- Intake: #00146736 - Follow-up related to plan of care.
- Intake: #00148039/Critical Incident System (CIS) #2918-000015-25 and Intake: #00148353/CIS #2918-000016-25 were related to falls prevention and management.
- Intake: #00149718 was related to a complaint concerning resident's improper repositioning and skin and wound care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1402-0002 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
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.

The licensee has failed to ensure that care set out in the care plan was provided to a resident as specified in their plan. The resident's care plan indicated that they required specific staff assistance for Activity of Daily Living (ADL). Screenshots revealed that, on specified dates, a Personal Support Worker (PSW) was noted providing assistance to the resident without following specific instructions as per the resident's care plan.

Sources: Resident's clinical records, screenshots; interviews with PSW, and Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW utilized safe positioning techniques when assisting the resident. The resident's care plan indicated that staff was required to follow specific positioning techniques to assist the resident.

Video Surveillance revealed that on the morning of a specified date, the PSW used an unsafe positioning technique while assisting a resident in the bed.

Sources: Resident's clinical records, video surveillance; interviews with PSW, Physiotherapist and ADOC.

WRITTEN NOTIFICATION: Falls 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).

The licensee has failed to comply with their Falls Prevention & Management Program policy after a resident's fall, when the resident was transferred from the floor to the bed despite complaining of pain. The physician was not notified, and the resident was not immediately sent to the hospital for further evaluation.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with.

Specifically, the home's policy indicated that if there is suspicion or evidence of injury, the resident should not be moved, and the physician should be contacted and/or arrange for immediate transfer of the resident to the hospital.

Sources: Long-Term Care Home's (LTCH)'s investigation notes; Fall Prevention & Management Program Policy # VII-G-30.10 dated February 2, 2025, resident's clinical records; and interviews with Registered Practical Nurse (RPN), and ADOC.