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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: September 29, 2025
Inspection Number: 2025-1402-0004
Inspection Type: Critical Incident
Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Norfinch Community, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18, 22 - 24, 26 and 29, 2025

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00154959, CIS #2918-000018-25, was related to a disease outbreak.
- Intake: #00155868, CIS #2918-000019-25 and Intake: #00157520, CIS #2918-000020-25 were related to fall prevention and management program.

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 and injury interventions for a resident were included in their plan of care.

i) A registered staff member indicated that the resident utilized specific interventions to mitigate the risk of falls, but these interventions were not included in the resident's written plan of care.

ii) The resident was prescribed an intervention to manage the injury they sustained after a fall. This specific intervention was not observed on the resident during an observation by the inspector and the registered staff member stated that the intervention was not included in the resident’s written plan of care.

Sources: Review of the resident's clinical records, inspector observations, and interviews with staff members.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the registered staff collaborated with the physician in the development and implementation of the plan care for a resident.

The resident sustained a fall that resulted in injuries. An intervention was prescribed to manage these injuries; however, the registered staff did not collaborate with the attending physician to provide direction for the use of this specific intervention.

Sources: Review of the resident's clinical records, and interviews with staff members.

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 an intervention was provided to a resident as specified in the resident's written plan of care on a specific day. Subsequently, the resident fell and sustained an injury.

Sources: Resident's written plan of care and clinical records, and interview with staff members.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee has failed ensure that an outbreak management system was in place for reporting infectious disease outbreaks based on requirements under the Health Protection and Promotion Act.

According to the Home's outbreak management system, a suspect respiratory outbreak based was defined as two cases of acute respiratory illness with symptoms onset within 48 hours with an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission in the setting and testing was not available or all negative.

A suspected disease outbreak in a home area was not reported to the Public Health Unit, as per the home's procedure, until laboratory test results confirmed the infectious agent.

Sources: Residents' clinical records and interviews with staff members.