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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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: February 12, 2025

Inspection Number: 2025-1317-0001

Inspection Type:
Critical Incident

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

Long Term Care Home and City: Harmony Hills Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6,-7, 10-12, 2025

The following intake(s) were inspected:

- Intake: #00135810 - [Critical Incident (CI): 2832-000014-24] - related to a disease outbreak
- Intake: #00137945 - [CI: 2832-000001-25] - related to fall with injury

The following intake(s) were completed:

- Intake: #00135124 - [CI: 2832-000013-24] - related to a disease outbreak

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Additional Requirement 9.1 of the IPAC Standard for Long-Term Care Homes required Routine Practices be followed in the IPAC program. Specifically, s. 9.1 (b) around hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

On February 6, 2025, a PSW was observed assisting four residents with hand hygiene prior to their meal, while wearing the same pair of gloves. The PSW did not doff their gloves or perform hand hygiene after assisting each of the residents.

Sources: Inspector's observation; interview with a PSW.