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: October 10, 2025
Inspection Number: 2025-1321-0006
Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Fountain View Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26, 29, 2025 and October 1, 2, 3, 6, 7, 8, 9, 2025.

The following Critical Incident (CI) intake(s) were inspected:
- Intake #00157954 - CI #2836-000022-25 was related to neglect and improper continence care.
- Intake #00158348 - CI #2836-000023-25 was related to prevention of neglect and abuse.
- Intake #00158635 -CI #2836-000024-25 was related to improper care.

The following complaint intake(s) were inspected:
- Intake #00155968 was related to neglect, care concerns, and documentation.
- Intake #00158545 was related to falls prevention and management.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 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 resident a was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident".

A resident sustained injuries after being struck by another resident in the home.

Sources: Progress notes; Interview with Assistant Director of Care (ADOC).
[698]