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: December 22, 2025
Inspection Number: 2025-1321-0008
Inspection Type: Complaint
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): December 10-12, 15-16, 18-19, 22, 2025

The following intake(s) were inspected:

- Intake: #00162600 - complaint related to medication administration
- Intake: #00162687 - complaint related to allegations of improper care of residents
- Intake: #00163941 and intake :#00164225 - complaints related to unknown cause of injuries of a resident

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of

residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

A resident preferred to be transferred back to bed after meals. The resident was not assisted by a Personal Support Worker (PSW) although they clearly expressed their preference.

Sources: A resident's clinical records, interviews with the resident and staff.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

On an occasion, PSWs assisted a resident with showering in the shower room with the door open.

Sources: Interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident experienced pain. Registered staff were not informed by PSWs and the resident's pain was not assessed.

Sources: A resident's clinical records, investigation notes, disciplinary note and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Substitute Decision Maker (SDM) for a resident was not provided an opportunity to participate in the development and implementation of their plan of care related to medication management. The home made changes to the resident's medication and did not inform the SDM.

Sources: A resident's clinical records and interview the Director of Care (DOC).

WRITTEN NOTIFICATION: Plan of care

NC #005 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.

(i) A resident required a specific level of assistance with an Activities of Daily Living (ADL). On an occasion, a PSW did not provide the level of assistance when assisting the resident with care.

Sources: A resident's clinical records and interviews with staff.

(ii) A resident required a specific level of assistance with ADLs. The level of assistance was not provided to the resident on an occasion.

Sources: A resident's clinical records, disciplinary notes, video footage and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A resident's plan of care stated that they required assistance with transfers. The resident and staff members indicated that the resident sometimes required a device for transfers. The resident's plan of care was not reviewed and revised, when the resident's care needs changed.

Sources: A resident's clinical records and interviews with the resident and staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A resident sustained injuries after they were assisted with care. A Registered Nurse (RN) did not report to the Director when they had reasonable grounds to suspect improper or incompetent treatment or care of the resident that resulted in harm to the resident.

Sources: A resident's clinical records and interview with an RN.

WRITTEN NOTIFICATION: Plan of care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 9.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis.

A resident's plan of care was not developed based on, at a minimum, an interdisciplinary assessment as it was related to their disease diagnosis.

The resident was discharged from hospital with new diagnoses. The resident's plan of care did not include an assessment or interventions related to management of their new diagnoses.

An interview with the DOC, confirmed that there was a miscommunication between the home and the physician to include the resident's diagnosis in the clinical records but should have been.

Sources: A resident's clinical records and and interview the DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

A resident exhibited responsive behaviours when staff assisted them with care. The behavioural trigger and intervention to manage the resident's responsive behaviour were not included in the resident’s plan of care.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident's plan of care directed staff members to wait and reapproach if resident refused care. PSWs did not implement the strategy to manage resident's responsive behaviour when the resident became aggressive during care and staff continued care.

Sources: A resident's clinical records and interviews with staff.