

**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:** March 4, 2026

**Inspection Number:** 2026-1321-0002

**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): February 19-20, 23-24, 26-27, 2026 and March 3-4, 2026.

The inspection occurred offsite on the following date(s): February 23, 2026.

The following intakes were inspected during this critical incident (CI) inspection:

- Intake: #00165557 [CI #2836-000034-25] was related to a infectious disease outbreak.
- Intake: #00166529 [CI #2836-000036-25] and #00169886 [CI #2836-000005-26] were related to alleged improper care.
- Intake: #00167675 [CI #2836-000002-26] was related to an unwitnessed fall that resulted in injury.
- Intake: #00167917 [CI #2836-000003-26, 2836-000004-26] were related to catheter care.

The following intake was inspected during this complaint inspection:

- Intake: #00167654 was related to alleged abuse and improper care.
- Intake: #00168374 was related to catheter care and treatment of infection.
- Intake: #00169137 was related to catheter care, bowel management and alleged improper care.

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

Resident Care and Support Services  
Contenance Care  
Infection Prevention and Control

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

Safe and Secure Home  
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 (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.

A registered staff observed a potential post-fall injury to a resident while they were in bed. The registered staff did not collaborate with Personal Support Workers (PSWs) on the resident's care when they failed to advise the PSWs to leave the resident in bed, and they were subsequently transferred from the bed. The resident was later identified to have an injury.

**Sources:** Resident's clinical record, the home's investigation notes, home's policy "Falls Prevention & Management, VII-G-30.10" (Last Revised August, 2025), interviews with PSWs and registered staff.

### WRITTEN NOTIFICATION: Plan of care

NC #002 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.

Resident's plan of care stated that they required assistance with an activity of daily living. A PSW completed the activity of daily living without the appropriate level of

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

assistance that the resident required. The resident later developed an injury that was a source of pain.

**Sources:** CI 2836-000036-25, the home's investigation notes, resident's plan of care and staff interviews.

### **WRITTEN NOTIFICATION: Continence care and bowel management**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

#### **Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)**

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

Resident's plan of care related to continence included a physician's order that was not implemented as per schedule.

**Sources:** Treatment administration record, home's investigation interview, physician's order and staff interview.

### **COMPLIANCE ORDER CO #001 Transferring and positioning techniques**

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

#### **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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. Following receipt of this order conduct audits on each unit for a specified period to ensure that when PSWs transfer residents, they do so in a safe manner which would

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

- include the right equipment and number of staff members to complete the transfer.
2. In addition, following receipt of this order conduct audits of PSWs for a specified period to observe for the appropriate use of transferring devices and techniques.
  3. Conduct on the spot education if there are any breaches to the above.
  4. Maintain a record of the audits, to include but not limited to audit dates, person(s) completing the audits, residents observed during the transfers, audit findings and any actions or education taken in response to the audit findings.
  5. Retain all records until the Ministry of Long-Term Care has deemed that this order has been complied with.

### Grounds

- 1) A PSW was preparing a resident for transfer without additional staff being present to assist. During the transfer, the resident experienced pain. The resident was later found to have an injury.

Failure to assist this resident using safe transferring techniques resulted in an injury.

**Sources:** CI 2836-000036-25, the home's investigation notes, resident's plan of care and staff interviews.

- 2) A resident required a specific level of assistance with transfers. The resident was transferred using a different method following a fall. The resident was later identified to have an injury.

Failure to use safe transferring techniques increased the risk of worsening existing injuries or sustaining new injuries.

**Sources:** Resident's clinical records , home's investigation notes, and staff interviews.

**This order must be complied with by April 13, 2026**

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

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

**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

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).