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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 14, 2026
Original Report Issue Date: April 30, 2026
Inspection Number: 2026-1321-0004 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Fountain View Community, Toronto

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change a date that was found in the Licensee Report

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17, 20-24, 27-30, 2026

The following intake(s) were inspected:
- Intake: #00172435 - Follow-up related to safe transferring
- Intake: #00173501 – Critical Incident (CI) related to improper care of a resident
- Intake: #00166138 – Complaint related to missed medications
- Intake: #00173570 – Complaint related to improper care of a resident
- Intake: #00173577 - Complaint related to concerns of abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2026-1321-0002 related to O. Reg. 246/22

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect

AMENDED 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) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The home was made aware that one resident had been disrespectful towards another resident which caused the disrespected resident to be upset.

Sources: Two residents' clinical records, and interviews with a resident, a Registered Practical Nurse (RPN) and the Director of Care (DOC).

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) 16.
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:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

A Personal Support Worker (PSW) dislodged a medical device while providing care which resulted in a resident expressing discomfort.

Sources: A CI report, the home's investigation notes, video footage, and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On multiple occasions, a resident was abusive toward another resident, resulting in a risk of harm. These incidents were not reported to the Director.

Sources: Two residents' clinical records, and interviews with an RPN and DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

During an observation, an intervention was not in place for a resident who had a history of responsive behaviours.

Sources: A resident's clinical records and interviews with an RPN and the DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident's medications were not administered as prescribed.

Sources: A photograph, a resident’s medication administration record and progress notes as well as interviews with the DOC and other staff.