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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: December 1, 2025
Inspection Number: 2025-1451-0007
Inspection Type: Complaint Critical Incident
Licensee: The Mennonite Home Association of York County
Long Term Care Home and City: Parkview Home Long-Term Care, Stouffville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 26, 27, 28, 2025 and December 1, 2025

The following intake(s) were inspected:
- Two intakes related to allegation of Neglect.
- One intake related to Outbreak.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Police notification

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse

or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The home's policy for zero tolerance of abuse and neglect directs staff to notify the appropriate police force of allegations of abuse and neglect.

The Director of Clinical Operations (DCO) acknowledged the police was not provided notification for alleged neglect of a resident.

Sources: Zero Tolerance of Resident Abuse Policy, and interview with the DCO.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The home was in a confirmed Disease outbreak declared by York Region Public Health. The Director was not immediately informed until the next day.

Sources: Critical Incident Report (CIR) and interview with the Infection Prevention and Control (IPAC) lead.

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