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 6, 2025
Inspection Number: 2025-1485-0004
Inspection Type: Critical Incident
Licensee: Belmont House
Long Term Care Home and City: Belmont House, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 22, 23, 25, 26, 2025 and October 1, 2, 6, 2025
The inspection occurred offsite on the following date(s): September 24, 25, 2025 and October 3, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intakes: #00152222, #00154396, and #00158024, all related to a disease outbreak;
- Intake: #00153875, related to a fall with injury and;
- Intakes: #00155961 and #00157464, both related to an injury of unknown cause.

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

Resident Care and Support Services
Infection Prevention and Control
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) (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.

The licensee has failed to ensure that the registered staff collaborated with the physician in the assessment of a resident, so that their assessments were consistent with and complemented each other.

The registered staff assessed the resident to have a change in medical condition and the physician was not notified of the change, which was acknowledged by a registered nurse.

Sources: Record review of a resident's clinical records and interview with a RN.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that a resident's symptoms indicating the presence of infection were monitored every shift, which was acknowledged by the Infection Prevention and Control Lead (IPAC).

Sources: A resident's clinical records and interview with the IPAC Lead.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that immediate action was taken to reduce transmission and isolate a resident when they exhibited symptoms indicating the presence of infection. The resident exhibited symptoms of infection and was not placed on isolation immediately.

Sources: Critical Incident Report, outbreak line list, a resident's clinical records; and interview with the IPAC Lead.