Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Public Report

Report Issue Date: September 29, 2025
Inspection Number: 2025-1317-0003
Inspection Type: Critical Incident
Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Harmony Hills Community, Toronto

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 22-24, 26, 29, 2025.

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00156676 – [CIS: 2832-000009-25] – was related to a fall with injury
- Intakes: #00157347 – [CIS: 2832-000010-25] – was related to a communicable disease outbreak

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

(i) Additional Requirement 9.1 of the IPAC Standard for Long-Term Care Homes required Routine Practices be followed in the IPAC program. Specifically, s. 9.1 (b) around hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

A Personal Support Worker (PSW) was observed assisting residents with their hand hygiene prior to their meal, while wearing the same pair of gloves. The PSW did not doff their gloves or perform hand hygiene after assisting each of the residents.

Sources: Inspector's observation; interviews with a PSW and the IPAC Lead

(ii) Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (f) stated that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Additional Precautions shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

A PSW doffed their PPE in an incorrect sequence after providing care to a resident who was on droplet and contact precautions.

Sources: Inspector’s observation; home’s Taking Off PPE diagram (Public Health Ontario); and interviews with a PSW and IPAC Lead.