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**
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# Public Report

**Report Issue Date:** May 2, 2025

**Inspection Number:** 2025-1321-0002

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** 2063414 Ontario Limited as General Partner of 2063414 Investment LP

**Long Term Care Home and City:** Fountain View Community, Toronto

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22, 24-25, 28-30, 2025 and May 1-2, 2025.

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

- Intake #00139917-CI #2836-000004-25 was related to falls prevention and management.
- Intake #00144912-CI #2836-000009-25/2836-000010-25 was related to the prevention of abuse and neglect.
- Intake #00144209-CI #2836-000006-25/2836-000007-25 was related to responsive behaviors and skin and wound care.

The following Complaint intake was inspected:

- Intake #00144162 was related to responsive behaviors and skin and wound care.

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

Skin and Wound Prevention and Management
Responsive Behaviours
Prevention of Abuse and Neglect

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 (1) (c)**
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provided direct care to the resident.

A resident required assistance from staff for eating at meals. A PSW provided the resident with a tray in the resident's room but was not able to get the resident to eat after 10 minutes. The resident's plan of care did not contain clear directions to staff on re-approaching and encouraging the resident to eat at meals.

**Sources:** Review of a resident's clinical record; and interviews with PSW and other 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 (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; and

The licensee has failed to ensure that staff and others involved in the care of a resident collaborated with each other, to ensure their assessments were integrated and were consistent with and complemented each other.

The Physiotherapist (PT) assessed a resident post-fall and, a post-fall assessment was completed by a nursing staff and both recommended fall prevention interventions to be implemented for this resident. These assessments were not communicated to the care team or integrated into the plan of care for the resident.

**Sources**: Review of a resident's clinical records, interview with the Falls Lead and other staff.

## WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed after the PT recommended interventions to reduce the risk of falls and injury for the resident.

**Sources:** A resident's clinical records and interviews with PSW and other staff.

## WRITTEN NOTIFICATION: Dress

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 44**
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee has failed to ensure that a resident was assisted to be dressed appropriately when being transferred to hospital during cold weather without a coat or jacket

**Sources:** a resident's clinical records, and interview with RPN.