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: June 9, 2025
Inspection Number: 2025-1359-0004
Inspection Type: Critical Incident Follow up
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Weston Terrace Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-6, and 9, 2025

The following intake(s) were inspected:

- Intake: #00142025 - Follow-up related to plan of care.
- Intake: #00146480/Critical Incident System (CIS) #2874-000026-25 was related to falls prevention and management.
- Intake: #00147442/CIS #2874-000027-25 and Intake: #00148008/CIS #2874-000029-25 were related to communicable disease outbreaks.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1359-0002 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services

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 the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with by a Personal Support Worker (PSW) student.

In accordance with Additional Requirement 9.1 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that the PSW student followed routine practices and performed hand hygiene before and after touching three residents and their equipment.

Sources: Observation of meal service in the dining room.

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) (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 the symptoms of infection for a resident were recorded, on every shift, while they were symptomatic during a respiratory outbreak. The resident's symptoms were not recorded on three shifts while they were on isolation precautions.

Sources: Resident's clinical records, interview with Registered Practical Nurse (RPN) and IPAC Lead.