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:** September 5, 2025
**Inspection Number:** 2025-1333-0004
**Inspection Type:**
Complaint
Critical Incident

**Licensee:** West Park Healthcare Centre
**Long Term Care Home and City:** West Park Long Term Care Centre, Toronto

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26, 28, 2025 and September 2-5, 2025.
The inspection occurred offsite on the following date(s): August 29, 2025.

The following complaint intake was inspected:
-Intake: #00152237 related to concerns with multiple aspects of care.

The following Critical Incident (CI) intakes were inspected:
-Intake: #00150101/ CI #2848-000014-25 related to an allegation of physical abuse.
-Intake: #00153797/ CI #2848-000019-25 related to falls prevention program and management.
-Intake: #00152193/ CI #2848-000018-25 related to improper transferring and positioning techniques resulting in an injury.

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

Resident Care and Support Services
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) (a)**
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,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care, related a personal care task, set out the planned care for the resident. The resident's care plan did not specify the level of assistance required for an identified care intervention. The Assistant Director of Care (ADOC) acknowledged that the plan of care should have specified the required level of assistance needed.

**Sources:** Resident clinical records, interviews with 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 (7)**
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in residents' plan of care was provided as specified in their plan.

i. A resident's plan of care directed staff to ensure that the resident's falls prevention device was within their reach while in bed. On a certain date, the resident was observed in bed without the device within reach.

**Sources:** Observation of the resident, resident's clinical record and interview with staff.

ii. Another resident's plan of care directed staff to ensure the resident's falls prevention device was within their reach. On a certain date, the resident was observed in their room without the device within reach.

**Sources:** Observation of the resident, resident's clinical records and interview with staff.

## WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the Director was immediately notified of an allegation of physical abuse of a resident.

In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Act, and pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

A resident reported an incident of alleged physical abuse to a PSW. This was reported to the ADOC by a Registered Nurse (RN) on the same day. However, the Director was not notified of the alleged physical abuse until four days later.

**Sources:** Resident's clinical records, CI and interviews with staff.

## WRITTEN NOTIFICATION: Communication Method

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 47**
Communication methods
s. 47. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

The licensee has failed to ensure that strategies developed to facilitate communication

with a resident were implemented.

i. The resident's plan of care directed staff to use a specific method of communication. However, on a particular day, a PSW did not follow the required communication approach while assisting the resident with an activity of daily living (ADL).

**Sources:** Home's investigation notes, resident's clinical records, interviews with the resident and staff

ii. On a different day, another PSW was observed attempting to communicate with the resident about their needs without using the communication method specified in the resident's plan of care.

**Sources:** Observation of the resident, resident's clinical records and interview with staff.

## WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #005 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 licensee has failed to ensure that the appropriate Police service was immediately notified of the alleged incident of physical abuse of a resident. A resident reported an incident of alleged physical abuse to a PSW. This was reported to the ADOC by a RN on the same day. However, Police was not notified of the alleged physical abuse until six days later.

**Sources:** Resident's clinical records and interviews with staff.

## WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (2)**
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a prescription medication was administered to a resident in accordance with the directions for use specified by the prescriber. A review of the electronic Medication Administration Record (eMAR) revealed that two doses of the medication were missed during a specific month. Registered Nurses confirmed that the medication was not given as prescribed.

**Sources:** Resident's clinical records, and interviews with staff.

## WRITTEN NOTIFICATION: Administration of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (6)**
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee has failed to ensure that prescriber approval was received in consultation with the resident before the resident administered a medication to themselves. A review of the eMAR showed that the resident self-administered the medication on a specific day. Registered Nurses confirmed that the medication is a prescription drug and should be administered by nursing staff. There was no documented physician or nurse practitioner order, nor any consultation note authorizing the resident to self-administer the medication.

**Sources:** Resident's clinical records, Interviews with staff.