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: December 11, 2025
Inspection Number: 2025-1333-0006
Inspection Type: Complaint
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 dates: December 4-5, and 9-11, 2025

The following complaint intake was inspected:
-Intake #00163176 was related to falls prevention and management.

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

Resident Care and Support Services
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;

A Personal Support Worker (PSW) used an assistive device to position a resident in bed. Another PSW reported that they used the assistive device. The Registered

Practical Nurse (RPN), Assistant Director of Care (ADOC), and Director of Care (DOC) confirmed this intervention was not written in the resident's care plan as required.

Sources: Observation of the resident's room, resident's clinical record, and interviews with the PSWs, RPN, ADOC and DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident was positioned unsafely in bed. The ADOC and the DOC reviewed a photograph of the resident in the unsafe position. They acknowledged that the resident was at risk of falling out of the bed and that the care staff should have used a different technique to safely position the resident.

Sources: Photograph of the resident, interviews with the ADOC and DOC.