

# 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**

5700 Yonge Street, 5th Floor Toronto, ON, M2M 4K5 Telephone: (866) 311-8002

## **Public Report**

Report Issue Date: April 30, 2025

Inspection Number: 2025-1359-0003

**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): April 17, 22, 24, 25, 28-30, 2025.

The following intake was inspected in this Follow-Up inspection:

Intake: #00138892, related to medication incidents and adverse drug reactions.

The following intakes were inspected in this Critical Incident inspection:

Intake: #00140308, related to a resident fall resulting in an injury. Intake: #00141840, related to resident-to-resident physical abuse.

Intake: #00141912, related to a disease outbreak.

The following intakes were completed in this inspection:

Intakes: #00141929 and #00142807, related to resident fall resulting in an injury.

Intakes: #00144057 and #00145060, related to a disease outbreak.

### **Previously Issued Compliance Order(s)**

The following previously issued Compliance Order(s) were found to be in compliance:



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Order #001 from Inspection #2025-1359-0001 related to O. Reg. 246/22, s. 147 (2) (a)

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

## **INSPECTION RESULTS**

### WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

In accordance with the definition identified in Ontario Regulation 246/22 section 2, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

On a specific date, a resident used physical force when they came in contact with another resident, causing the co-resident to sustain an injury and further



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treatment.

**Sources:** Resident's health records, the home's video surveillance notes, and interviews with staff.

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