

**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

<b>Report Issue Date:</b> November 10, 2025
<b>Inspection Number:</b> 2025-1359-0008
<b>Inspection Type:</b> Critical Incident Follow up
<b>Licensee:</b> 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
<b>Long Term Care Home and City:</b> Weston Terrace Community, Toronto

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4-7, 10, 2025

The following intake(s) were inspected in this Follow Up inspection:

- Intake: #00154169 - Follow-up Compliance order related to the Infection Prevention and Control (IPAC) program

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

- Intake: #00157274 [CI #2874-000048-25] – related to physical abuse
- Intake: #00160494 [CI #2874-000057-25] – related to fall prevention and management

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:  
Order #001 from Inspection #2025-1359-0005 related to O. Reg. 246/22, s. 102 (8)

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

Infection Prevention and Control  
Prevention of Abuse and Neglect  
Falls Prevention and Management

## INSPECTION RESULTS

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## WRITTEN NOTIFICATION: Police Record Check

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

Non-compliance with: O. Reg. 79/10, s. 215 (3)

Police record check

s. 215 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. O. Reg. 451/18, s. 3 (1).

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 215 (3) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 252 (3) of the FLTCA.

A Personal Support Worker (PSW) was hired on a specific date, and after review of the home's records it was revealed that a vulnerable sector check was not on file for this PSW.

The Associate Director of Care (ADOC) acknowledged that the PSW's vulnerable sector check was not obtained upon hire.

**Sources:** PSW's onboarding files and interview with the ADOC.

## WRITTEN NOTIFICATION: Duty to Protect

NC #002 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.

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"Emotional abuse" means any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment, or infantilization performed by anyone other than a resident.

A PSW engaged in a verbal and physical altercation with a resident who exhibited responsive behaviours.

The PSW responded to the resident's behaviour by using inappropriate gestures and actions.

The ADOC acknowledged that the resident experienced emotional abuse during the above interaction involving the resident and PSW.

**Sources:** Resident's clinical records, video footage of the incident, interviews with a PSW and the ADOC.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident's care plan provided specific interventions for managing their responsive behaviours.

A PSW did not implement the strategies in the resident's care plan when they engaged in a verbal and physical altercation with the resident.

The ADOC acknowledged the PSW failed to implement the strategies identified in the

resident's care plan.

**Sources:** Resident's clinical records, video footage of the incident, interviews with a PSW and the ADOC.