Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: January 12, 2026
Inspection Number: 2026-1359-0001
Inspection Type: Critical Incident
Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: Weston Terrace Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6-9 and 12, 2026

The following Critical Incident System (CIS) intake(s) were inspected:

Intake: #00164505/ CIS #2874-000060-25 and Intake: #00165459/ CIS# 2874-000061-25 - related to fall prevention and management program.

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

Housekeeping, Laundry and Maintenance Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home To Be Safe, Secure Environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

During an observation, an environmental hazard related to building maintenance was

identified in the residents' home area. Temporary mitigation measures were in place, but the unsupervised area posed a risk to the residents.

Sources: Observations; interviews with the Environmental Services Manager, Registered Nurses (RNs), Assistant Director of Care (ADOC) and Director of Care (DOC)

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident fell and sustained an injury. The resident's mobility support requirements were not clearly defined in their care plan, resulting in inconsistent assistance with their mobility needs.

Sources: Video surveillance records, the resident’s care plan, and interviews with the Personal Support Worker (PSW), Registered Practical Nurse (RPN) and ADOC.

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's Falls Prevention & Management policy required staff to ensure the resident was not moved before the nurse completed a preliminary assessment following a fall incident.

On a specific date, after a resident fell, staff moved the resident before the nurse completed an assessment.

Sources: Review of the resident's progress notes, post-fall assessment, home's investigation notes, home's falls prevention policy; interviews with the PSW and RN.