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

## Original Public Report

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|---|---|
| **Report Issue Date:** April 26 2023 | |
| **Inspection Number:** 2023-1607-0003 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** City of Toronto | |
| **Long Term Care Home and City:** Wesburn Manor, Etobicoke | |
| **Lead Inspector**<br>Maya Kuzmin (741674) | **Inspector Digital Signature**<br>Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.04.27 16:32:36 -04'00' |
| **Additional Inspector(s)**<br>Patricia McFadgen (000756) was also present during this inspection. | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27-31 and April 3-4, 2023.

The following intakes were completed in the complaint inspection:

- Intake: #00020833 - was a complaint related to Infection Prevention and Control (IPAC).

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00017782 – was related to injury of unknown cause.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

**NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)**
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, the licensee failed to ensure that point-of care signage indicating that enhanced IPAC control measures are in place, as required by Additional Precautions 9.1 (e) under the IPAC standard.

On an identified date, a droplet contact precautions (DCP) sign was posted outside on residents' room indicating specific personal protective equipment (PPE) to be worn by staff.

Personal Support Worker (PSW) # 111 and Registered Practical Nurse (RPN) #101 acknowledged that DCP poster was to be removed due to residents not being isolated at present time. PSW # 111 removed the DCP poster.

There was no risk of harm to the residents in the room when additional precaution signage was not removed when no longer needed.

Sources: observations and interviews with PSW # 111 and RPN 101.

[741674]

Date Remedy Implemented: March 27, 2023