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

Report Issue Date: November 29, 2023	
Inspection Number: 2023-1607-0006	
Inspection Type: Complaint	
Licensee: City of Toronto	
Long Term Care Home and City: Wesburn Manor, Etobicoke	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.11.29 16:21:38 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 14, 15, 20, 21, 23, 2023

The following intake(s) were completed in this complaint inspection:

- Intake #00097562 and Intake #00101048 were related to multiple concerns related to resident care and staff to resident abuse
- Intake: #00098682 and Intake #00098983 were related to staff to resident abuse

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

- Intake #00099060/CIM612-000015-23 was related to staff to resident abuse

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Food Production

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee failed to ensure that the food tray for resident was safely stored on November 15, 2023.

Rationale and Summary:

Inspector observed that a resident's food tray was in the resident's room at a particular time.

The home's policy stated that a Registered Nurse (RN)/Registered Practical Nurse (RPN) was to complete a Tray Service Audit and notify Food and Nutrition department of any changes or concerns.

A direct care staff stated they delivered the food tray at a specific time. A direct care staff and registered staff stated that they were provided with direction by the resident's family to leave food trays in the resident's room until the family arrives.

Nutrition Manager (NM) explained that a resident's food tray was only to be provided to the PCA/Personal Support Worker (PSW) staff once resident is prepared and ready to eat. They acknowledged that storing the food tray in the resident's room did not meet the food safety standards. The NM was not informed by the nursing staff that the food tray would remain in the resident's room for numerous hours.

Failure to meet food safety standards related to meal tray storage placed the resident at risk for contracting a food borne illness.

Sources: Observations November 15, 2023; Resident's Care Plan; Tray Service Policy RC-0523-21 (Published 15-08-2022); interviews with staff.

[741674]