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

Public Report

Report Issue Date: May 27, 2025
Inspection Number: 2025-1607-0002
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Wesburn Manor, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13, 14, 16, 20, 22, 23, 26 and 27, 2025

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

- Intake: #00141629 [CI #M612-000004-25]- related to a fall of a resident resulting in injury
- Intake: #00141768 [CI #M612-000005-25]- related to an outbreak
- Intake: #00143643 [CI #M612-000007-25]- related to an outbreak
- Intake: #00143696 [CI #M612-000008-25] - related to unknown cause of injury to a resident

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques after a resident had a fall that resulted in a fracture. The resident was transferred without the indicated device following a fall incident, which placed them at risk for further injury.

Sources: Resident's clinical records, the home's Falls Prevention and Management/No Lift Policy; and interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, resident's symptoms indicating

the presence of infection were monitored.

During an outbreak, a resident experienced symptoms and was placed on additional precautions. The required respiratory illness assessment for monitoring of symptoms of infection was not completed during two shifts on an identified date

Sources: Resident's clinical records; and interview with Infection Prevention and Control (IPAC) Manager.