

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: July 12, 2024

Inspection Number: 2024-1607-0002

Inspection Type:Critical Incident (CI)

Licensee: City of Toronto

Long Term Care Home and City: Wesburn Manor, Etobicoke

Lead Inspector

Inspector Digital Signature

Manish Patel (740841)

Additional Inspector(s)

Rachel Dioquino (000856) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 2 - 5, 8 and 9, 2024.

The following intake(s) were inspected:

- Intake: #00117161 / CI #M612-000014-24 was related to disease outbreak.
- Intake: #00118068 / CI #M612-000015-24 was related to a fall.
- Intake: #00118500 / CI #M612-000018-24 was related to abuse.

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

- Intake: #00112629 / CI #M612-000008-24 and Intake: #00115711 / CI #M612-000011-24 - were related to disease outbreak.
- Intake: #00112673 / CI #M612-00009-24 was related to a fall.



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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 4.

Reporting certain matters to Director

- s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
- 4. Misuse or misappropriation of a resident's money.

The licensee has failed to ensure that a person who has reasonable grounds to suspect the misuse or misappropriation of a resident's money has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

The home received a verbal concern from a family member of a resident, alleging inappropriate use of personal TV and personal landline phone. Verbal complaint was also received by Head Office staff and relayed to the Long-Term Care home via email. The concerns outlined specifically over \$200 in charges for movies /



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international calls in a period of a month.

Review of Critical Incident (CI) noted that the Director was informed of this four days after becoming aware of the concern.

Assistant Administrator and Nurse Manager (NM) confirmed that the suspected financial abuse should have been reported to the Director immediately, and acknowledged late reporting.

Failure to immediately report the alleged financial abuse to the Director posed no risk to the resident.

Sources

CI, Zero Tolerance to Abuse and Neglect Policy with Policy and corporate e-mail, Interview with Assistant Administrator and NM.
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