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
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Original Public Report

Report Issue Date: February 21, 2024	
Inspection Number: 2024-1515-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Wexford Residence Inc.	
Long Term Care Home and City: The Wexford, Scarborough	
Lead Inspector Manish Patel (740841)	**Inspector Digital Signature**
Additional Inspector(s) Lisa Salonen Mackay (000761)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 1, 2, 5 - 9, 12 and 13, 2024

The following intake(s) were inspected:

- Intake: #00107889 for Proactive Compliance Inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Food, Nutrition and Hydration

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (2)
Dietary services and hydration
s. 15 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The licensee has failed to ensure that residents #001 and #012 were provided fluids that were at a safe consistency.

Rationale and Summary:
Residents #001 and #012 were to be provided fluids with a modified consistencies.

A dietary aid (DA) was observed providing resident #001 with different consistencies at meal service. Foodservice Supervisor (FSS) confirmed that different consistencies were provided.

On another occasion, it was observed that a Personal Support Worker (PSW) provided resident #012 with fluids at a consistency that were not safe for the resident. The PSW stated that the instructions on the product container used to modify the fluid consistency were too small to read.

Failure to provide residents with fluids at consistencies that were safe, placed the residents at risk for choking and aspiration.

Sources: Observations; diet orders; interviews with DA, PSW and FSS.
[000761]

WRITTEN NOTIFICATION: Food, Nutrition and Hydration

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that residents on pureed texture diets were offered snack.

Rationale and Summary:
A PSW was observed delivering snacks without referencing the snack menu. Residents on pureed texture diets were not provided pureed cookie as per snack

menu.

The PSW acknowledged the snack menu should have been used and residents did not receive pureed cookies as per the planned menu.

Foodservice Manager (FSM) stated that the expectation was for staff to refer to the snack binder and all residents should have been offered the planned texture modified snack.

Failure to provide pureed snacks, placed the residents at risk for decreased nutritional intake.

Sources: Observations; review of snack binder; interviews with PSW and FSM. [000761]