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
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Public Report

Report Issue Date: February 21, 2025
Inspection Number: 2025-1515-0001
Inspection Type: Complaint Critical Incident
Licensee: The Wexford Residence Inc.
Long Term Care Home and City: The Wexford, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 14, and 18-21, 2025.
The inspection occurred offsite on the following date(s): February 13, 2025.

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake #00133884 related to falls prevention and management.
- Intake #00136933 related to infectious disease outbreak.

The following Complaint intake(s) were inspected:
- Intake #00139611 related to prevention of abuse and neglect.

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

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

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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care set out a planned falls prevention intervention that had been provided to the resident for several months. The intervention was added to the resident's written plan of care after it was brought to the home's attention during the onsite inspection.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means any form of verbal communication of a threatening or intimidating

nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During a shift, staff witnessed a resident being yelled at in a raised tone by a person other than a resident. The interaction occurred in front of other residents and staff, and could be considered as belittling, degrading, and potentially diminishing the resident's dignity and self-worth. The resident was upset afterward.

Sources: Resident's progress notes, staff report; interviews with staff and the Director of Care (DOC).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the suspicion of abuse of a resident was immediately reported to the Director. During a shift, staff witnessed a resident being yelled at and believed that abuse of the resident had occurred or might occur. They reported the incident to management; however, the suspicion was not reported to the Director as required.

Sources: Resident's progress notes, staff report; interviews with staff and the DOC.