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: April 24, 2025

Inspection Number: 2025-1515-0002

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): April 14-17, 22, 24, 2025

The following intake(s) were inspected:

- Intake: #00140423 - Critical Incident (CI) #3021-000004-25 was related to Falls Prevention and Management Program.
- Intake: #00142746 - CI 3021-000006-25 was related to a disease outbreak.
- Intake: #00143542 - was a complaint related to Prevention of Abuse and Neglect, Minimizing of Restraining and Residents' Bill of Rights.

The following intake(s) was completed

- Intake: #00140357 - CI #3021-000002-25 was related to a disease outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provide direct care to the resident.

A fall prevention intervention was observed on left side of a resident's bed. The resident's plan of care did not specify which side of the bed the intervention should be placed on. A Registered Practical Nurse (RPN) and a Physiotherapist (PT) confirmed that the fall prevention intervention should be placed on the right side of the bed due to the resident's health condition.

The RPN and PT acknowledged that the plan of care did not provide clear direction to staff regarding the location of the fall prevention intervention for the resident.

Sources: Review of the resident's clinical record; and interviews with a RPN and a PT.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The license has failed to ensure that Personal Protective Equipment (PPE) was removed in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) as required by Additional Requirements 9.1(d) under the IPAC Standard.

A Personal Support Worker (PSW) exited a resident's room, who was on additional precautions, and did not remove PPE before proceeding to another resident's room. The PSW acknowledged that they failed to remove PPE upon exiting the resident 's room. The IPAC Lead confirmed that the staff were to remove PPE after exiting a resident's room on additional precautions.

Sources: Observations, review of IPAC Standards and interview with a PSW and the IPAC Lead.