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: September 16, 2025
Inspection Number: 2025-1607-0003
Inspection Type: Complaint 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): August 26, 28-29, 2025 and September 2-4, 8-9, 12, 16, 2025

The following intake was inspected in this complaint inspection:
- Intake: #00151940- Complaint related to air conditioning

The following intake was inspected in this Critical Incident (CI) inspection:
- Intake: #00155149/ CI #M612-000016-25 - related to injury of unknown cause

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff collaborated with each other to ensure a resident received the treatment they required in a timely manner.

On a specified date, registered staff members received clinical results that required the immediate attention of a physician. The registered staff members delayed notification to the physician until the next day. Subsequently, the resident did not receive the required interventions for a period of time.

Sources: Investigation notes for Critical Incident System (CIS), a resident's clinical records, and interview with the Acting Director of Nursing (ADON).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an immediate report was made to the Director when there were reasonable grounds to suspect improper care of three residents.

An investigation conducted in the home revealed that on specified dates, three residents were improperly transferred by staff using a specific device with only one staff member, though the residents' care plans noted two staff members were required. The incidents were not immediately reported to the Director.

Sources: CIS report, the residents clinical records, video footage from the specified dates, and interview with the ADON.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1a. Develop and implement an audit to ensure that staff transfer the identified residents with the level of assistance and directions required as per their care plans. The audit should be conducted at minimum, two times a week for the residents, equally on day and evening shifts, for a period of two weeks following the service of this order.

1b. Develop and implement random audits to ensure that the identified staff perform transfers with the level of assistance and directions required as indicated in residents care plans. The audit should be conducted at minimum, one shift per week per staff member for a period of two weeks following the service of this order.

1c. Maintain a record of the audits completed in items 1a and 1b, including dates, shift times, audit time, the name of the person completing the audits, resident and staff names being audited, resident's care plan transfer directions, observations made, audit findings and content of on-the-spot education provided and/or other corrective actions taken where required.

2a. Re-train the identified staff on the home's lift and transfer policy and the identified residents care planned transfer status.

2b. Maintain a record of all the education and training provided as specified above in item 2a, including the training content, date, name and signature of attending staff, and the name of the person(s) who provided the education.

3.Retain all records until the Ministry of Long-Term Care (MLTC) has deemed that this

order has been complied with.

Grounds

The licensee has failed to ensure that three staff members used safe transferring techniques when assisting four residents.

A resident was found with a change in status and was subsequently diagnosed with an injury. During the home's investigation, multiple incidents of unsafe transfers were identified on video footage.

On specified dates and shifts, four residents were improperly transferred by three staff members using a specific device with only one staff member, though the resident's care plans noted two staff members were required. The identified staff members all acknowledged they transferred the residents independently, though their care plans indicated that two-person assistance was required for safe use of the device.

Failure to perform the transfers with the required level of assistance increased the risk of injury to the residents.

Sources: Investigation notes, home's video footage, the residents clinical records, and interviews with the staff members and ADON.

This order must be complied with by October 20, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.