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

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| **Report Issue Date:** December 9, 2025 |
| **Inspection Number:** 2025-1607-0005 |
| **Inspection Type:**<br>Complaint<br>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): November 28, 2025 and December 1-5, 8, 9, 2025
The following Complaint intake(s) was inspected:
Intake: #00160988 was related to an allegation of neglect and improper care of a resident.
The following Critical Incident System (CI) intake was inspected:
Intake: #00162907 (CI-M612-000028-25) was related to fall prevention and management.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Falls Prevention and Management

## 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) (a)**
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident experienced changes to their health condition over one month. The staff did not collaborate with the physician/Nurse Practitioner in the home regarding the resident's plan of care. Subsequently, the resident experienced negative outcomes.

**Sources:** Clinical records of a resident, interviews with staff.

## WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.**
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

A resident was found on the floor in a non-residential area and they experienced a change in their health condition that required medical intervention. Staff acknowledged the area should have been locked to restrict unsupervised access to residents.

**Sources:** Clinical record of a resident; interviews with staff.

## WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's Fall Prevention and Management policy required staff to complete a specific assessment upon a resident's re-admission from hospital if the resident was identified to be high risk for falls. A resident was re-admitted from the hospital, however, the registered staff did not complete this assessment and later the resident had an unwitnessed fall resulting in an injury.

**Sources:** Fall Prevention and Management Policy; interviews with staff.

## WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 54 (1)**
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The resident's care plan indicated a specific fall intervention to reduce risk of falls. A resident had an unwitnessed fall and they were not wearing the specific fall intervention prior to the fall. The resident experienced a negative health outcome requiring medical intervention.

**Sources:** Clinical records of a resident; interviews with staff.