



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
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**Public Copy/Copie du public**

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|------------------------------------------------|-----------------------------------------------|--------------------------------|----------------------------------------------------|
| Sep 12, 2013                                   | 2013_195166_0028                              | O-000753-<br>13                | Complaint                                          |

**Licensee/Titulaire de permis**

THE WEXFORD RESIDENCE INC.  
1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1

**Long-Term Care Home/Foyer de soins de longue durée**

THE WEXFORD  
1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

CAROLINE TOMPKINS (166)

**Inspection Summary/Résumé de l'inspection**



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 27, 28, 29 2013

Non compliance related to LTCHA 2007, s.6(1)(c) has been identified in this inspection and will be reflected under inspection 2013\_220111\_0016

During the course of the inspection, the inspector(s) spoke with the Resident, Family members, the Physician, the Director of Care, Registered staff, Personal Support staff and Housekeeping staff

During the course of the inspection, the inspector(s) reviewed the resident's clinical health records, the licensee's policy and procedures related to the prevention of abuse and the licensee's policy and procedures related to responsive behaviours.

The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES |                                       |
|----------------------------------------------|---------------------------------------|
| Legend                                       | Legendé                               |
| WN – Written Notification                    | WN – Avis écrit                       |
| VPC – Voluntary Plan of Correction           | VPC – Plan de redressement volontaire |
| DR – Director Referral                       | DR – Aiguillage au directeur          |
| CO – Compliance Order                        | CO – Ordre de conformité              |
| WAO – Work and Activity Order                | WAO – Ordres : travaux et activités   |



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**



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1. The licensee failed to immediately notify the Director of an incident of alleged staff to resident abuse.

Clinical documentation confirms the Director of Care was notified of the alleged staff to resident abuse incident on August 6, 2013. The Director was notified of the alleged abuse incident on August 8, 2013. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee shall ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred shall immediately report the suspicion and the information upon on which it is based is immediately reported to the Director., to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

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**Findings/Faits saillants :**

1. The licensee failed to immediately notify the police of an alleged incident of staff to resident abuse.

Clinical documentation confirms the Director of Care was notified of an alleged incident of staff to resident abuse on August 6, 2013. The police were notified of the incident on August 8, 2013. [s. 98.]



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***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse that the licensee suspects may constitute a criminal offence., to be implemented voluntarily.***

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Issued on this 12th day of September, 2013

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

A handwritten signature in black ink, appearing to read "Carol Thompson", written within a rectangular box.