Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2021	2020_751649_0028	010371-20, 020874-20, 022991-20, 023211-20, 025004-20	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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 23, 30 (off-site), 31, 2020, January 4, 5, 6, 7, 8, 11, and 15 (off-site), 2021.

The following intakes were completed during this Complaint Inspection:
Log #010371-20 related to skin and wound care.
Log #020874-20 related to administration of drugs, prevention of abuse and neglect, continence care and bowel management, and plan of care.
Log #022991-20 related to plan of care.
Log #023211-20 related to infection prevention and control program (IPAC), Residents' Bill of Rights, and plan of care.
Log #025004-20 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Physician, Nurse Practitioner (NP), Nurse Managers (NMs), Registered Nurses (RNs), Physiotherapist (PT), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Care and Services Administrative Assistant, Housekeeper, Family Member, and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to showers.

As a result of non-compliance identified for a resident the sample was expanded to this resident.

A resident's shower records were reviewed for the period of three months in 2020. According to this record the resident received six bed baths and three showers during one month, and seven bed baths and one shower during the other month. Their care plan indicated that their preference was to have showers. A review of the resident's progress notes indicated that they were on isolation for approximately one week during the review period. Then the home went into a respiratory outbreak at the beginning of November 2020 which remained in effect during this inspection. A review of their shower records indicated that they were provided with 13 bed baths when they should have received showers, therefore their care plan was not followed. The resident did not experience any negative outcome.

Sources: Review of the resident's health records, progress notes, care plan, interviews with DOC, and other staff. [s. 6. (7)]

2. As a result of non-compliance identified for a resident the sample was expanded to the resident below.

A resident's shower records were reviewed for three months in 2020. Their care plan

indicated that they were scheduled for showers twice weekly. The resident was not on isolation during the review period. During the review period the resident was provided with bed baths on four occasions when they should have received showers. As a result of this review, the resident's care plan was not followed. The resident did not experience any negative outcome.

Sources: Review of the resident's health records, progress notes, care plan, interviews with DOC, and other staff. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A resident's shower records were reviewed for several months in 2020 related to a reported concern. During the same period the resident was on lengthy periods of isolation, and received bed baths in lieu of their scheduled showers. The resident experienced a change in health status mid-year which affected their posture in their mobility device. According to a staff member, the resident's posture had become unsafe therefore bed baths were provided for the resident's safety. As a result of this change, the resident's care plan should have been revised and updated when this change had occurred.

Sources: Review of the resident's health records, progress notes, care plan, interviews with DOC, other staff, and Substitute Decision-Maker (SDM). [s. 6. (10) (b)]

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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident, who exhibited altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A resident sustained an area of altered skin integrity. A referral was not made to the RD when the area of altered skin integrity occurred therefore the resident was not assessed. The area of altered skin integrity healed approximately three weeks later.

Sources: Review of the resident's health records, progress notes, interviews with DOC, other staff, and resident's SDM. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that three residents who exhibited altered skin integrity, were assessed at least weekly by a member of the registered nursing staff, when clinically indicated.

(i) A resident sustained an area of altered skin integrity. Registered staff failed to complete five weekly skin and wound assessments after the area of altered skin integrity was identified.The site healed approximately two months later.

(ii) The same resident sustained a second area of altered skin integrity. Registered staff failed to complete two consecutive weekly skin and wound assessments after the area of altered skin integrity was identified. The next weekly skin and wound assessment was completed when the site had healed.

(iii) As a result of non-compliance identified for the above mentioned resident the sample was expanded to this resident who sustained an area of altered skin integrity. Registered staff failed to complete six weekly skin and wound assessments. The site healed approximately 11 weeks after it was first identified.

(iv) As a result of non-compliance identified for a resident the sample was expanded to this resident who sustained an area of altered skin integrity. Registered staff failed to complete two consecutive weekly skin and wound assessments. The site healed less than a month later after it was first identified.

Sources: Review of the residents' health records, progress notes, electronic medication administration records (e-TARs), interviews with DOC, other staff, and resident #001's SDM. [s. 50. (2) (b) (iv)]

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 to ensure a resident exhibiting altered skin integrity, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program (IPAC) in the home.

(i) The inspector observed a staff member assisting a resident with their meal. The staff was observed wearing a mask and face shield at the time of the observation. Droplet/contact precaution signage along with a yellow bag on the resident's door indicated that the staff were required to wear a mask, face shield, gown and gloves. This observation was witnessed by a physician who provided on the spot education to the staff.

(ii) The inspector observed a Housekeeper inside a resident's room. Signage on the resident's door along with a yellow bag indicated that the resident was on droplet/contact precautions. The Housekeeper immediately acknowledged that they should have been wearing full personal protective equipment (PPE) including gown and gloves, and was observed wearing this when they reentered the resident's room.

Sources: Review of the residents' health records, progress notes, interviews with DOC, and other staff. [s. 229. (4)]

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 to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

During a resident's meal, furniture in their room with their personal belongings was packed up by a staff member. One of the resident's SDMs was present with the resident at the time and asked the staff member to wait for the second SDM and they would do it together. The resident's SDM and the staff member had a verbal altercation inside the resident room. The home had not obtained prior approval from the resident's SDMs to remove the resident's personal belongings on this specific day. There was no indication that a deadline was provided to the resident's SDMs to have the resident's personal belongings packed up in attempt to declutter the room due to ongoing safety concerns. All of this had occurred suddenly in the presence of the resident.

Sources: Review of the resident's progress notes, interviews with DOC, other staff, and Substitute Decision-Maker (SDM). [s. 3. (1) 1.]

Issued on this 11th day of February, 2021

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

Original report signed by the inspector.