Ontario

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 12, 2013	2013_195166_0019	O-002408-12,O-000515-13	Critical Incident System

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

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 21, 24, 2013

This Inspection was initiated to inspect 2 critical incidents, log O-002408-12 and log O-000515-13.
The non compliance identified in log O-0002408-12 under LTCHA 2007,s.23.(2) and s,24(1)have been issued as a Written Notification(WN) and Voluntary Plan of Correction(VPC) on July 18, 2013 as part of Compliant Inspection, 2013_195166_0020.

During the course of the inspection, the inspector(s) spoke with an identified resident, the resident's Power of Attorney(POA), the Administrator, the Director of Care (DOC), a Registered Practical Nurse (RPN), Personal Support Workers (PSW), the Food Service Supervisor, the Dietitian and a Dietary Aide(DA).

During the course of the inspection, the inspector(s) reviewed the clinical health records for 2 identified residents, the licensee's investigation documentation, the licensee's policies related to Dining and Snack Service, Assistance in the Dining Room, Feeding Residents and Zero Tolerance of Abuse and Neglect of Residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Dignity, Choice and Privacy

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee failed to ensure that the Director is immediately informed,in as much detail as is possible of an unexpected or sudden death.
Log O-00515-13
The licensee submitted critical incident #C579-000024-13 indicating Resident #03 experienced a choking incident while being fed at a meal time. Resident #03 was transferred to the hospital for further treatment and died later the same day. There is no documented evidence that the Director was immediately informed of the unexpected death of Resident #03. [s. 107. (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 to ensure the Director is immediately informed in as much detail as possible of an unexpected or sudden death of a resident., to be implemented voluntarily.

WN #2: 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 :

The licensee failed to ensure that the right of a resident to be treated with dignity was fully respected and promoted.
Log O-00515-13
The licensee submitted critical incident #C579-000036-12 which indicated an alleged incident of staff to resident abuse/neglect. The critical incident documentation indicated the nurse manager during morning rounds in a resident home area, heard a cry from Resident #04's room and discovered Resident #04 lying on the floor, uncovered and partially dressed.
When the nurse manager inquired why Resident #04 was on the floor, documentation indicated the PSW responded by saying the "resident was not cooperating" and needed time to "calm down". [s. 3.(1) 1.]

WN #3: 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. (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 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

Log O-00515-13
The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other.
The licensee submitted critical incident #C579-000024-13 indicating Resident #03 experienced a choking incident while being fed by PSW (S01). Clinical documentation indicated the resident had a history of congestion and coughing while being fed.

Interview with(PSW)(S02) indicated the dietitian had informed PSW (S02)to hold Resident #03's meal until the dietitian was able to come to the dining room to observe and assess the resident.
Interview with the RPN indicated she had not been informed of the dietitian's request to hold Resident #03's meal until the dietitian was able to be in the dining room to observe and assess the resident.
Interview with the Dietary Aide indicated, she had not been informed to hold serving Resident #03's meal until the dietitian had an opportunity to be in the dining room to observe and assess the resident.
Interview with PSW(S01) indicated she had not been informed that the dietitian had requested Resident #03's meal be held until the dietitian was able to come to the dining room to observe and assess the resident.
[s.6.(4)(b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

Log O-002408-12
The licensee submitted critical incident #C579-000036-12 which indicated an alleged incident of staff to resident abuse/neglect.
Clinical documentation indicated Resident #04's POA was notified the resident had fallen. There is no documented evidence that Resident #04's POA was notified of a an alleged incident of staff to resident abuse/neglect.
Interview with Resident #04's POA confirmed, the POA was not notified of the alleged staff to resident abuse/neglect. [s.97.(1)(a)]

WN #5: 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.

Findings/Faits saillants :

Log O-002408-12
The licensee failed to ensure that the appropriate police force was immediately notified of any alleged incident of abuse or neglect of a resident.
The licensee submitted critical incident #C579-000036-12 which indicated an alleged incident of staff to resident abuse/neglect.
There is no documented evidence, the appropriate police force was notified of the alleged abuse/neglect. [s. 98.]

Issued on this 12th day of August, 2013

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