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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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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 13, 2013	2013_220111_0013	002302, 001719	Follow up

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 18, 24, 25, 27 & July 2, 2013.

Log 001719 was completed as a critical incident inspection under inspection 2013_220111_0014 but non-compliance was identified in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Physiotherapist (PT), 3 Personal Support Workers (PSW), 2 Registered Nurses (RN),

During the course of the inspection, the inspector(s) observed resident care for two resident's, reviewed staff training records, reviewed the homes investigation reports and the homes policy of Falls Prevention Management.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

Related to log 002302:

O.Reg. 79/10, s.36 was issued as a Compliance Order on October 22, 2012 as part of inspection 2012_048175_0017 and had a compliance date of November 19, 2012. The home was required to submit a compliance plan to ensure that staff use safe transfer and positioning devices when assisting residents.

Review of the homes corrective action plan indicated under "plan of action":
- "Review of safe transfer and positioning devices with staff, as well as review our policy on mobility and minimal lift. Staff to complete questionnaire on completion of review. In-service scheduled for November 7 and 14th 2012 for all shifts".
-"Nurse manager/designate will audit work practices weekly for 2 weeks then monthly thereafter to ensure compliance"
-The plan indicated the plan of action was to be completed by November 15, 2012 (by the DOC).

Interview of the DOC indicated there were no work practice audits completed and training was completed by the Physiotherapist. The DOC also indicated that not all staff received the falls prevention training.

Interview of the Physiotherapist (PT) and review of the staff training records 2012 for "falls prevention and management" indicated an in-service was provided on November 7, 2012 by the PT on "Safe lifts and transfers" and only 24 staff attended. [s. 221. (1) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

Related to log # 001719:

A Critical Incident Report (CI) was received for an improper/incompetent treatment of a resident that resulted in harm. The CI indicated Resident #1 was being assisted with a transfer from bed to wheelchair with assistance of one PSW. The resident fell and sustained an injury.

Review of the plan of care for Resident #1 indicated the resident required a two person assist with all transfers.

Interview of the DOC and review of the home's investigation indicated the PSW involved in the incident had improperly transferred the resident.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

O.Reg. 79/10, s.36 was issued as a Compliance Order on October 22, 2012 as part of inspection 2012_048175_0017 and had a compliance date of November 19, 2012. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

LTCHA 2007, s.6 was issued as a Compliance Order on May 22, 2013 as part of inspection 2013_00111_006 under LTCHA 2007, s.19 and had a compliance date of June 30, 2013.

1. Related to log #001719:

A Critical Incident Report (CI) was received for an improper/incompetent treatment of a resident that resulted in harm. The CI indicated Resident #1 was being assisted in a transfer from bed to wheelchair by one staff member. The resident fell and sustained an injury.

Review of the plan of care for Resident #1 indicated the resident required two staff to assist with each transfer.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. Related to log #002302:

Review of the progress notes for resident #2 indicated:
-The resident was found half-hanging out of the bed. The resident sustained an injury to right hand.
-Four days later, the resident was found caught between the side-rail and the bed with upper torso hanging out of the bed. The resident sustained an injury to the right arm. The resident's injury did not improve, and eight days later, the resident was transferred to hospital for x-ray (with no fracture).
-Ten days later, the resident was found half-hanging out of bed with head on the floor. A crash mat was in place and no injuries noted.

Review of the plan of care for Resident #2 (post incidents)indicated:
1) Risk of Falls related to history of spontaneous fracture of lower leg, non-weight bearing, (last fall noted was three months prior to recent incidents). Interventions included: call bell pinned to gown when in bed, check every 15-30 minutes, lower the bed to lowest position, place a floor mat at the side of the bed when in bed, and reinforce need to call for assistance.There was no documented evidence of every 15-30 minutes checks.There was no indication of risk for falls related to climbing out of bed and any other interventions to reduce the risk of injury.

The licensee failed to ensure when the plan of care is revised because care set out in the plan has not been effective related to falls prevention, that different approaches were considered in the revision of the plan of care. [s. 6. (11) (b)]

Issued on this 16th day of August, 2013

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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 performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2013_220111_0013
Log No. / Registre no:	002302, 001719
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 13, 2013
Licensee / Titulaire de permis :	THE WEXFORD RESIDENCE INC. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	THE WEXFORD 1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY BASSETT

To THE WEXFORD RESIDENCE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The home is to ensure that all staff who provide direct care to residents are trained in the home's falls prevention and management program.

Grounds / Motifs :

1. Related to log 002302:

O.Reg. 79/10, s.36 was issued as a Compliance Order on October 22, 2012 as part of inspection 2012_048175_0017 and had a compliance date of November 19, 2012. The home was required to submit a compliance plan to ensure that staff use safe transfer and positioning devices when assisting residents.

Review of the homes corrective action plan indicated under "plan of action":
- "Review of safe transfer and positioning devices with staff, as well as review our policy on mobility and minimal lift. Staff to complete questionnaire on completion of review. In-service scheduled for November 7 and 14th 2012 for all shifts".
-"Nurse manager/designate will audit work practices weekly for 2 weeks then monthly thereafter to ensure compliance"
-The plan indicated the plan of action was to be completed by November 15, 2012 (by the DOC).

Interview of the DOC indicated there were no work practice audits completed and training was completed by the Physiotherapist. The DOC also indicated that not all staff received the falls prevention training.

Interview of the Physiotherapist (PT) and review of the staff training records 2012 for "falls prevention and management" indicated an in-service was provided on November 7, 2012 by the PT on "Safe lifts and transfers" and only 24 staff attended. [s. 221. (1) 1.] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_048175_0017, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff who provide direct care to residents use safe transferring and positioning devices or techniques when assisting residents .

Grounds / Motifs :

1. Related to log # 001719:

A Critical Incident Report (CI) was received for an improper/incompetent treatment of a resident that resulted in harm. The CI indicated Resident #1 was being assisted with a transfer from bed to wheelchair with assistance of one PSW. The resident fell and sustained an injury.

Review of the plan of care for Resident #1 indicated the resident required a two person assist with all transfers.

Interview of the DOC and review of the home's investigation indicated the PSW involved in the incident had improperly transferred the resident.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

O.Reg. 79/10, s.36 was issued as a Compliance Order on October 22, 2012 as part of inspection 2012_048175_0017 and had a compliance date of November 19, 2012. [s. 36.] (111)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of August, 2013

Signature of Inspector / Signature de l'inspecteur : L Brown

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

Service Area Office / Bureau régional de services : Ottawa Service Area Office