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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2015	2015_302600_0007	T-2204-15	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

GORDANA KRSTEVSKA (600)

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): April 15-16, 2015.

**During the course of the inspection, the inspector(s) spoke with the executive director (ED),two nurse managers (NM), life enrichment staff, resident assessment instrument minimum data set (RAI MDS) coordinator,
registered practical nurses (RPN), personal support workers (PSW), housekeepers, and resident.**

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

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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	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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Record review and staff interview revealed that resident #1 was identified to be at risk for unpredictable responsive behaviours including verbal and physical aggression.

Record review revealed that resident #1's behavior escalated after an incident which occurred on identified date when resident #3 hit resident #1 twice in the face for no apparent reason and without provocation.

Review of the progress notes on specified dates revealed resident #1 made a death threat against resident #3 telling the staff to keep resident #3 away from him/her or he/she would kill resident #3. The police were notified and the licensee then implemented 1:1 staffing for 72 hours to provide constant supervision. Dementia Observation system (DOS) was implemented after the 72 hours to be completed every 15 minutes.

Review of progress notes on specified dates revealed that resident #1 told the staff that he/she punched resident #2 causing the resident to fall to the floor and sustain bruising. Resident #1 was placed on 1:1 monitoring until he/she could be seen by the outside professional.

The POP team visited the resident on specified dates and arranged to follow up with the specialist for escalation of behaviours. New interventions included to continue with the 1:1 until behaviours have settled and consider a telephone for the resident and wander alerts on the elevators so that the resident could be considered for a different care unit.

A progress note from specified dates revealed resident #1's behaviours continued when he/she had a verbal outburst toward his/her roommate, resident #4 due to the roommate being incontinent and the accompanying odors. Resident #1 threatened physical harm toward resident #4. 1:1 staffing was still in place providing constant supervision.

On specified date and time the inspector observed the staff member who was assigned to provide 1 to 1 care for resident #1 to be standing outside of the resident's room, with the door closed, while the resident #1 was inside the room. The roommate was also in

the bedroom behind the closed door. Resident #1 was not being monitored by the staff who was assigned to provide 1:1 constant supervision as indicated in the resident's written plan of care.

The identified staff member confirmed that he/she knew what 1:1 supervision meant and further confirmed that he/she was not monitoring resident #1 at the identified time when resident #1 was behind the door with the roommate who was previously threatened by him/her.

Interview with the registered staff confirmed that the 1:1 care provider did not follow the plan of care which directed the 1:1 staff to attend to all of resident #1's needs and to provide constant supervision to ensure residents are safe from resident #1's unpredictable physical aggression. The registered staff member further revealed that she does not have a system of monitoring the staff member assigned to 1:1 care. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

Issued on this 9th day of June, 2015

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

Original report signed by the inspector.