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
Apr 17, 2015	2015_302600_0005	T-526-14, T-1339-14, T-1205-14, T-404-14, T-599-14	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), JOANNE ZAHUR (589)

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): March 16, 17, 18, 19, 20, 23, 2015.

During the course of the inspection, the inspector(s) spoke with director of care (DOC), coordinator staff development/CQI & ICP, nursing managers (NMs), personal support workers (PSWs), registered staff, physiotherapy (PT), occupational therapist (OT), program manager (PM).
The inspectors conducted observation on medication administration system, staff and resident interactions and the provision of care, review of clinical health records, complaint and critical incident record log, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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 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 is provided to the resident as specified in the plan.

Review of resident #2's health record reveals that two staff are to be present when completing care activities related to unpredictable behaviour. On a specified date and time, an identified PSW provided a shower to resident #2 without the assistance of a second staff member. At the end of the shower, resident #2 exhibited unpredictable behaviour resulting in the above mentioned PSW requiring the assistance of a second PSW.
An interview with an identified PSW and an identified registered staff member confirmed that on specified date and time, a shower was provided to resident #2 by one staff.

Review of the resident #1's plan of care revealed the resident requires assistance for toileting during specific times throughout the day and evening and frequent check for toileting needs, especially at night.
A call-bell system record review revealed that on specified day resident #1 rang the call bell 8 times during the night, for assistance with toileting. The review of Home's investigation revealed the PSW had responded to the call bell but had not assisted the resident with toileting as per the plan of care. Resident #1 had made four calls for assistance between between 6:26a.m. and 6:55 a.m.
Interview with the identified staff member confirmed the resident had rang the call bell numerous times on the specified date. The staff member stated the call bell was responded to, but confirmed that he/she did not assist the resident with toileting because the PSW was alone on the unit at that time, and other staff were already toileting other

residents.

Record review revealed on an identified day, resident #4 returned from the hospital after treatment for an injury. The written plan of care for resident #4 directed the staff to provide the treatment within 5 to 7 days.
However, two days after the resident returned from the hospital, the staff provided the treatment of the injury. The attending
physician confirmed that the staff had failed to follow the medical plan of care and provided the treatment prior to when the physician had ordered. This resulted in resident #4 having to remain on bed rest for several days.
Interview with the identified registered staff confirmed that the staff did not provide the treatment to facilitate healing as specified in the plan of care. [s. 6. (7)]

2. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

Record review revealed resident #4 was assessed by the physiotherapist (PT) on identified day for mobility and transfers. A sit-to-stand lift was recommended as a transferring device.
Record review of the progress notes from identified period revealed that the resident's overall health condition declined.
- Resident #4 was assessed by outside professionals.
- During a transfer with the sit-to-stand lift, resident #4 sustained an injury
- Two days after the incident, the PT assessment revealed that resident #4 required a full sling ceiling lift for all transfers.
Interview with nurse managers confirmed that resident #4 should have been reassessed, and the plan of care reviewed and revised for transferring when the resident's condition deteriorated between identified period. [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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time 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 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every licensee of a long term care home shall ensure that the following rights of residents are fully respected and promoted specifically, that every resident has the right not to be neglected by the licensee or staff.

Review of the home's investigation related to a critical incident from a specified date, revealed at 9:50 p.m., an identified PSW gave a shower to resident #2 without the assistance of another staff member. After the shower the identified PSW required the assistance of a second PSW as the resident became resistive. As a result, the two PSWs were unable to properly dress resident #2, covering him/her with a sheet and transferring back to the resident's room where further attempts to dress the resident were unsuccessful. The PSWs left the resident unclothed and covered with a sheet sitting in a wheelchair in the resident's room. They did not report this incident to the registered staff. At approximately 10:20 p.m., the resident's SDM arrived finding resident unclothed sitting in the wheelchair alone in his/her room. At this time, the evening NM was notified. A second shower was given immediately and resident #2 was dressed into night clothes and settled for the night.
Interview with the registered staff member revealed he/she received a phone call from the SDM reporting concerns about the way resident #2 was left. After completing an assessment of resident #2 the identified registered staff contacted the SDM and indicated no soap residue was noted but failed to inform the SDM that the staff were unable to clothe the resident in his/her night clothes.
Review of resident #2's written plan of care reveals two staff are to be present when providing care needs and showers.
Interview with an identified NM confirmed resident #2 was left undressed in his/her room from approximately 9:15 p.m. to 10:20 p.m.
w sentence:
Resident #2's right not to be neglected by the licensee or staff was not promoted when the resident was left undressed in his/her room for 35 minutes.

Issued on this 29th day of June, 2015

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

Original report signed by the inspector.