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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Mar 14, 2017	2017_630589_0004	003425-17	Resident Quality Inspection

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

JOANNE ZAHUR (589), ANGIE KING (644), BABITHA SHANMUGANANDAPALA (673), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 9, 10, 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, March 1 & 2, 2017.

The following inspections were completed concurrently with the resident quality inspection (RQI):
Complaints: #018694-16 related to plan of care and maintenance, #019567-16 and 026621-16,related to safe and secure home, #019568-16 related to dealing with complaints, #019691-16 related to plan of care and no interference by the licensee, #019879-16 related to plan of care and continence care and bowel management, and #029832-16 related to dining and snack service,
Critical incident system report intakes: #017907-16 related to abuse, #029474-16 related to injury of unknown cause, and #017714-16 and 002630-16 related to falls prevention,
Follow-up inspections to the following orders: #027865-16 related to abuse prevention and #027868-16 related to plan of care, and
Inquiry inspection: #003927-17 related to non-allowable resident charges and abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Nurse Managers (NMs), Director of Environmental Services (DES), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Housekeeping Aides (HA), Registered Dietician (RD), Food Services Supervisor (FSM), Physiotherapist (PT), Wound Care Nurse (WCN), Social Services Coordinator (SSC), Director of Services and Programs (DSP), Resident Assessment Instrument-Minimum Data System (RAI-MDS) coordinator, Administrative Assistant (AA), Substitute Decision Makers (SDM), nursing students and residents.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_321501_0009	589
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2016_321501_0009	644

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008 was protected from abuse by anyone.

The Ministry of Health and Long Term Care (MOHLTC) received critical incident system report (CIS) which revealed that staff #134 was not gentle to resident #008's during care. The CIS further revealed that staff #134 denied the allegation and continued to provide care while further stating to resident #008 that he/she had other care to provide.

Review of resident #008's written plan of care revealed that he/she was not ambulatory and required total care.

In an interview, resident #008 stated he/she vaguely remembered the incident as it occurred some time ago however, he/she did remember that a staff member had not been gentle with him/her during care. Review of the resident assessment instrument-minimum data set (RAI-MDS) quarterly assessment for resident #008's revealed his/her cognitive performance scale score was 0/30, indicating no cognitive impairment.

Review of the home's investigation notes and staff #134's personnel file revealed that he/she had received a discipline for the above mentioned incident involving resident #008.

In an interview, staff #134 stated he/she had provided care to resident #008 and that an identified body area had altered skin integrity. Staff #134 further stated he/she continued to provide care to resident #008 despite his/her complaints of not receiving gentle care.

In an interview, staff #102 confirmed that the home had failed to ensure that resident #008 had been protected from abuse. [s. 19. (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 that resident #008 was protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with a range of continence care products that are based on their individual assessed needs, promote resident comfort, ease of use, dignity and good skin integrity, and promote continued independence wherever possible.

A complaint was sent to the MOHLTC related to resident #001 not being provided with continence care products that are based on his/her assessed needs.

At the time of the inspection resident #001 could not be interviewed. As a result, residents #012 and #025 with similar continence care needs were observed.

Review of resident #012's RAI-MDS quarterly assessment revealed the resident is continent of bowel and usually incontinent of bladder with occasional incontinent since an identified date in 2015. Further review revealed resident #012 required supervision with

continence care.

Review of the written plan of care revealed that resident #012 is independent with continence care, and has a history of removing continence care products provided by the home. The use of an alternative continence care product was to be trialed and family had been asked to provide them.

Review of the Admission Bladder and Bowel Continence Assessment completed for resident #012 revealed he/she had urinary incontinence, and he/she was not comfortable wearing the continence care products provided in the home.

In an interview, resident #012's family member stated that he/she was informed by the home to provide the alternative continence care product for trial use. The family member confirmed that this alternative continence care products was not offered by the home.

In interviews, staff #123 and #124 stated that the continence care products provided by the home had not met resident #012's assessed needs, and as a result, nursing staff had suggested the use of an alternative continence care product. Staff #124 stated that he/she informed staff #120, who called the family member. Staff #124 confirmed resident #012's family member had provided the alternative continence care product to the home the next day.

In an interview, staff #120 stated resident #012 was removing the continence care product provided by the home. A trial to use the alternative continence care product was initiated. Resident #012 was reassessed and the use of the alternative continence care product best met his/her continence care needs. He/she also confirmed that this alternative continence care product was not offered in the home due to cost effective measures and that family were required to provide them. [s. 51. (2) (h)]

2. Review of resident #025's written plan of care revealed when admitted to the home he/she was occasionally incontinent of urine and required an alternative type of continence care product.

Observations conducted by the inspector revealed three packages of the above mentioned continence care product in resident #025's closet.

In interviews, staff #135 and #136 stated that resident #025 requires continence care and the alternative continence care product is the only product the resident is comfortable

wearing.

In an interview, staff #120 stated that resident #025 was assessed and required the alternative continence care product as he/she would remove any other continence care product available in the home. Staff #120 confirmed that the alternative continence care product was being paid by an alternate source as the home does not provide them due to cost. [s. 51. (2) (h)]

3. A complaint was sent to the MOHLTC related to resident #001 not being provided with continence care products that are based on his/her assessed needs.

Review of resident #001's RAI-MDS quarterly assessment revealed that resident #001 occasionally requires continence care and uses an alternative continence care product.

Review of resident #001's progress notes revealed that staff had documented a voice mail message had been left for resident's #001's family member to provide the alternative continence care product which were brought to the home the next day.

Review of the home's Weekly Continence Product Count form for two identified weeks in June 2016, revealed that the home did not have available the alternative continence care product for resident continence care needs.

In interviews staff #115 and #121 both stated that resident #001 used an alternative continence care product for a four month period in 2016, which had been provided by the family.

In an interview, staff #122 stated that the home does not provide the alternative continence care product and that families provide them. Staff #122 further stated that a collaborative assessment, based on need and comfort is completed by staff on whether a resident could benefit from this alternative continence product and then the family is contacted, provided with an explanation of these benefits, and requested to provide them.

In an interview, staff #120, who is also the continence care program lead in the home, stated for cost effectiveness, alternative continence care products are only provided by the home when there is potential for continence care improvement and/or rehabilitation in a resident.

In an interview, staff #102 stated that if a resident has been assessed and there is a need for the alternative continence care product, the home should provide them. Staff #102's statement contradicts staff #120's statement and requests by the home for family member's of residents #001 and #012, and #025 to provide the alternative continence care products. [s. 51. (2) (h) (i)]

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 residents are provided with a range of continence care products that are based on their individual assessed needs, promote resident comfort, ease of use, dignity and good skin integrity, and promote continued independence wherever possible, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

The MOHLTC received a complaint related to resident #001's difficulty using the continence care products provided by the home.

Review of resident #001 plan of care revealed when the resident was admitted he/she was continent of bladder and required assistance with continence care needs. Further review of the written plan of care revealed that bladder continence had been resolved on an identified date in January 2016.

Review of RAI-MDS quarterly assessment revealed the following:

-resident #001's continence status had changed to occasional bladder incontinence at an identified time,

-resident #001 required the use of an alternative continence care product.

Observations conducted during this inspection revealed resident #001 now required full continence care.

In an interview, staff #121 stated that between a two month period in 2016, resident #001 was occasionally incontinent at an identified time and required assistance to meet continence care needs.

In interviews, staff #122 and #112, stated resident #001's written plans of care on two identified dates in 2016, had not set out the planned care for resident #001 based on the above mentioned quarterly assessments related to continence care. Staff #112 further stated that continence care had been resolved and it should not have been as resident #001 still required continence care.

In an interview, staff #120, stated that resident written plans of care related to continence care needs are updated every three months and as needed. Staff #120 further stated that resident #001's written plan of care had not set out the planned continence care needs for resident #001 based on quarterly assessments. [s. 6. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Continence Care and Bowel Management Program is in compliance with and is implemented in accordance with all applicable requirements under the Act, and is complied with.

A complaint was sent to the MOHLTC related to resident #001 not being provided with continence care products that were based on his/her assessed needs.

O. Reg. 79/10, s. 51. (2) states that residents are to be provided with a range of continence care products that are based on their individual assessed needs.

Review of the home's Continence Care and Bowel Management Program Index #E-10, revised on September 28, 2016, revealed that the home provides a range of continence care products that include various briefs and liners, while other continence care products such as an identified alternative continence care products may be purchased by family.

Review of resident #001, #012, #025's assessments, progress notes, and plan of care revealed the above residents were assessed for the use of alternative continence care products, and it was documented that their respective family were providing them.

In an interview, the family member confirmed that he/she had been asked by the nursing staff to purchase and provide the alternative continence care product as the continence care products available in the home were not meeting the resident needs.

In interview, staff #115, #122, #123, and #120 stated that residents are not provided with the alternative continence care products by the home even when assessed to require them based on their individualized needs.

In an interview, staff #102 confirmed that the home has been notifying resident family member's to provide the alternative continence care products therefore, the home's policy was not in compliance with the Act which requires the licensee to provide residents with a variety of continence care products that are based on their individual assessed needs. [s. 8. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints received concerning the care of a resident or the operation of the home are immediately forwarded to the Director.

The MOHLTC received a complaint from resident #001's family member. Review of the complaint revealed that resident #001's family member had taken the resident to see a specialist off-site. At the appointment the family member was asked to pay for the appointment as the Ontario Health Insurance Plan (OHIP) had recently been billed for a visit that had occurred in the long term care home. The complainant had emailed staff #119 requesting re-imbursement of monies paid.

Review of the home's Concerns and Complaints policy, policy #5.22, reviewed April 20, 2016, page 2, includes the definition of a complaint as being a concern related to the care of a resident or the operation of a home. It further defines a written complaint as including emails. Page 3 of the home's Concerns and Complaints policy states that written complaints are to be forwarded to senior management and to be immediately forwarded to the MOHLTC.

Review of the home's complaints binder and record revealed that a complaint had been received by staff #119 and #125 from resident #001's family member.

This complaint was then forwarded to staff #120, #125 and #102 indicating that a response had not yet been given to resident #001's family member.

Review of emails provided by staff #102 revealed that staff #103 had received the complaint with resident #001's family member's request for reimbursement of monies paid.

In an interview, staff #119 stated that the complaint met the requirements of a written complaint, however he/she had not forwarded it to the Director. Staff #119 further stated he/she had only forwarded the complaint to staff #120, #125 and #102.

In an interview, staff #102 stated that the complaint from resident #001's family member had not been forwarded to the Director.

In an interview, staff #103 stated that written complaints including email complaints concerning the care of a resident or operation of the home are to be reported to the Director. Staff #103 further stated that the complaint from resident #001's family member had not been reported to the Director. [s. 22. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (1) This section applies where a criminal reference check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 75 (2) of the Act. O. Reg. 79/10, s. 215 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks were conducted within six months before a staff member was hired.

Related to findings of non-compliance related to O. Reg. 79/10, s. 19 (1) during this inspection, five staff personnel files were reviewed.

Review of the personnel file for staff #146 revealed that he/she had been hired at the long term care home on an identified date in 2016. The personnel file further revealed that a police check had been completed on an identified date in 2016, seven months prior.

Review of staff #146's schedule for a six week period after his/her date of hire, revealed that staff #146 had worked a total of 18 shifts where he/she had provided resident care.

In an interview, staff #146 stated the police check on file was the only one he/she had provided to the home.

In an interview, staff #102 confirmed that a criminal reference check had not been conducted within six months of hire. [s. 215. (1)]

Issued on this 15th day of March, 2017

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

Original report signed by the inspector.