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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2018	2018_514566_0013	007370-17, 007766-17, 009796-17, 013761-17, 015365-17	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

ARIEL JONES (566), STELLA NG (507), SUSAN SQUIRES (109)

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): November 6, 7, 8, and 9, 2018.

The following Critical Incident System (CIS) inspections were conducted during this inspection: Log #007766-17 / CIS #C579-000007-17, Log #007370-17 / CIS #C579-000006-17, and Log #015365-17 / CIS #C579-000014-17 (related to duty to protect); Log #013761-17 / CIS #C579-000013-17 and Log #009796-17 / CIS #C579-000011-17 (related to falls prevention and management).

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Director of Finance, Director of Programs and Services, nurse manager (NM), physiotherapist (PT), registered nursing staff (RN/RPN), personal support workers (PSW), housekeeping aide, and residents.

During the course of the inspection, the inspector(s): observed staff-to-resident interactions, reviewed residents' health care records, relevant home policies and procedures, and investigation notes.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Légende 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. 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 :

1. The licensee has failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity was fully respected and promoted.

An identified critical incident report (CIR) was submitted to the Ministry of Health and Long-term Care (MOHLTC) for an incident which occurred on an identified date in 2017. According to the report, PSW #106 scared and intimidated resident #001 and their family after raising their voice, pointing their finger at the family members, and telling them that they had already provided a specific type of care to resident #001 earlier on their shift and the resident did not need to be provided the same type of care again.

Resident #001 was no longer in the home.

PSW #106 was interviewed and denied that they violated resident #001's rights. PSW #106 acknowledged that they were reprimanded and retrained on the home's abuse policy and residents' rights.

During an interview, housekeeper #107 told the inspector that they observed PSW #106's demeanor to be abusive to resident #001 and their family members when PSW #106 abruptly told housekeeper #107 to leave the room so PSW #106 could talk to the family alone. Housekeeper #107 told the inspector that they thought that the behaviour of PSW #106 was impolite and rude and stated that they considered it to be abusive.

In an interview, NM #110 stated that PSW #106 acted in an abusive manner to resident #001 when they raised their voice to the family in front of the resident, and repeatedly questioned the resident about their need for care which caused the resident to feel afraid and scolded. NM #110 confirmed that PSW #106 was reprimanded and retrained on the Residents' Bill of Rights and the home's zero tolerance of abuse policy. [s. 3. (1) 1.]

2. A second identified CIR was submitted to the MOHLTC related to an incident of verbal abuse which occurred on an identified date in 2017. Resident #002 told RN #117 that they were yelled at by a staff member. The CIR indicated that the resident was fearful to drink from the nourishment cart after the incident because they thought that the staff member might poison them.

Review of resident #002's progress notes from the identified date in 2017, indicated that

resident #002 reported to RN #117 at an identified time that PSW #120 yelled at them. During the conversation with the RN, PSW #120 approached the resident and in a loud voice asked the resident why they were lying and told them to stop.

Resident #002 was unable to recall the incident when interviewed.

During an interview, PSW #106 acknowledged that yelling and being rude is abusive, however denied that they yelled at or were abusive toward resident #002.

During an interview, RN #117 told the inspector that PSW #120's actions constituted verbal abuse of resident #002.

During an interview, DOC #101 told the inspector that verbal abuse was founded during the home's investigation, and that PSW #120 was reprimanded and retrained on the Residents' Bill of Rights and the home's zero tolerance of abuse policy. [s. 3. (1) 1.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

An identified CIR was submitted to the MOHLTC related to an incident of verbal abuse which occurred on an identified date in 2017. Resident #002 told RN #117 that they were yelled at by a staff member. The CIR indicated that the resident was fearful to drink from the nourishment cart after the incident because they thought that the staff member might poison them.

According to the home's policy entitled Zero Tolerance of Abuse and Neglect of Residents, section #6.46, staff were to immediately report any witnessed or alleged incident of abuse to the MOHLTC and to the appropriate supervisor in the home. The resident's substitute decision maker (SDM) should have been notified and an internal report filed. The abusive staff member was to be separated from the resident.

During an interview, RN #117 told the inspector that they did not follow the home's policy. The staff member stated that they did not report the witnessed incident to anyone until the day after the incident. Further to this, RN #117 did not contact the SDM or separate the accused staff member from the resident.

The DOC #101 told the inspector that it is the expectation of the home that the staff member followed the policy by separating the staff member from the resident, notifying the MOHLTC, contacting the family, and implementing the decision tree guide for abuse which would have directed the staff member to a supervisor. [s. 20. (1)]

Issued on this 14th day of November, 2018

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

Original report signed by the inspector.