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
Jan 30, 2019	2019_751649_0001	033000-18, 033334-18	Complaint

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

JULIEANN HING (649), ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 10, 11, 14, 15, 16, 17, 18, 21, 22, and 24, 2019.

The following intakes were inspected:
Complaint log #033000-18 related to bathing, nutrition and hydration, and falls prevention and management.
Complaint log #033334-18 related to laundry services, continence care and bowel management, dining and snack service, weight changes, falls prevention and management, qualifications of personal support workers, bathing, and plan of care.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), nurse manager (NM), registered nurses (RNs), food service manager (FSM), registered dietitian (RD), resident assessment instrument-minimum data set (RAI-MDS) coordinator, registered practical nurses (RPNs), personal support workers (PSWs), care companions, and chairman of Family Council, vice-chairperson of Family Council, and family members.

During the course of the inspection the inspectors observed staff to residents interactions, reviewed residents' health records, reviewed relevant policies and procedures, reviewed video footage, and observed the meal service.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Nutrition and Hydration
Personal Support Services

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	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 O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated:
- A change of 5 per cent of body weight, or more over one month;
- A change of 7.5 per cent of body weight, or more over three months; and
- A change of 10 per cent of body weight, or more over 6 months.

Complaints were received by the Ministry of Health and Long-Term Care (MOHLTC) regarding several areas of care provided in the home to resident #016. The complaints stated that the resident had been losing weight since admission and staff did not have enough time to assist them with feeding.

Review of resident #016's progress notes showed that they had been admitted to the home on an identified date and passed away in the home. Resident #016 was receiving a modified texture diet and required extensive assistance for feeding.

Review of resident #016's weight history showed a significant weight loss over an identified period.

In interviews, PSWs #105 and #123 indicated that resident #016 required assistance from staff with feeding, and had variable intake at meals. PSWs #105 and #123 additionally indicated that resident #016 was difficult to encourage to complete a meal if they had decided they did not want to eat.

Review of resident #016's progress notes showed documentation by RPN #126 indicating a weight change during an identified period of time, and that the resident ate very little at meals; sometimes refusing to eat. The progress note further indicated a referral had been sent to the RD. No RD referral was identified in Point Click Care (PCC), nor was an assessment of the weight changes identified in progress notes or resident records.

In interviews, RPNs #120 and #126 indicated that the process in the home when a resident had a weight change of 2kg or more was to reweigh the resident to confirm if it was an actual weight change. If the weight change of 2kg or more was confirmed registered staff would initiate a referral in PCC to the RD for assessment. RPN #126 further indicated that they had reviewed resident #016's weight change and had possibly forgotten to initiate the referral to the RD for assessment as they had indicated in the progress note.

In an interview, RD #128 indicated that the process in the home was that residents with identified weight changes of 2kg or more would be referred by registered staff in PCC to the RD for assessment. RD #128 indicated they would print the electronic referrals and respond within seven days. RD #128 indicated they had not received a referral related to resident #016's weight changes, and no assessment of the resident's weight changes was carried out. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances or the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Complaints were submitted to the MOHLTC expressing concerns about resident #016's repeated falls.

Record review indicated that resident #016 was admitted on an identified date and their care plan indicated that they were at high risk for falls.

Record review indicated that resident #016 had sustained a first fall on an identified date in an identified area of the home. This fall was witnessed by a staff member and the resident did not sustain any injuries. On another date, resident #016 sustained a second fall in an identified are of the home also witnessed by a staff member, no injuries were observed. The home completed one post fall assessment for the two falls instead of a post fall assessment after each fall, therefore no post fall assessment had been completed after the resident fell the first time.

In interviews with RPN #114 and 120, they confirmed that no post fall assessment had been completed when resident #016 sustained the first fall. According to RPN #114 one post fall assessment had been completed when the resident fell on the two dates.

In an interview with the DOC #101, they explained that the home completes a post fall assessment after every fall under the home's risk management module. According to the DOC there was a glitch with the post fall assessment, with these two falls days apart, the system showed that a post fall assessment was completed after each fall, when there was only one post fall assessment completed. [s. 49. (2)]

Issued on this 12th day of February, 2019

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

Original report signed by the inspector.