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
Jul 25, 2019	2019_767643_0022	009921-19	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

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): July 9, 10, 12 and 15-18, 2019.

The following complaint intake was inspected during this inspection:
Log #009921-19 - related to alleged neglect, medication management, nutrition and hydration and personal support services.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Practitioner (NP), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Director of Environmental Services (DES), Food Services Manager (FSM), Registered Dietitian (RD), Personal Support Workers (PSW), Dietary Aides (DA) residents and family members.

During the course of the inspection the inspector conducted observations of staff to resident interactions and the provision of care, dining service, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A written complaint was forwarded to the Director by the home from resident #010's family member related to care concerns for the resident. The letter indicated that resident #010 was hospitalized and had identified nutrition and hydration issues when they were admitted to hospital.

Review of resident #010's health records showed they were admitted to the home with identified diagnoses affecting their nutrition and hydration risks. Resident #010 was transferred to hospital on an identified date after complaining of pain, poor oral intake over three days, and two other identified symptoms. Review of hospital documentation showed resident #010 was treated in hospital to stabilize identified laboratory test values.

Review of resident #010's plan of care showed they had an identified calculated daily fluid requirement, with a minimum daily fluid requirement also identified. Staff were instructed to encourage intake of the minimum fluid requirement daily at meals and snacks. Resident #010's electronic Medication Administration Record (e-MAR) showed an additional identified volume of water was to be given at med pass twice daily.

Review of resident #010's point-of-care (POC) documentation in pointclickcare (PCC)

and e-MAR showed total daily fluid intakes which were below the above mentioned minimum daily fluid requirement on 11 of 12 of the days prior to admission to hospital.

In interviews, RNs #111, #112 and #114 indicated that the process in the home for monitoring resident fluid intake was for the night shift nurse to print out a list of residents on each unit and their 24-hour fluid intake from POC. The night shift staff would then add fluids given at med pass and any supplements administered to give a total fluid intake from all sources. RNs #112 and #114 indicated that when a resident was below their recommended fluid intake the day and evening nurses would begin to monitor the resident intake more closely over three days. RN #112 and #114 indicated that if the resident was not meeting fluid needs over that three day period a referral would be made to the interdisciplinary team members such as the NP, Physician and/or RD to assess the resident.

Review of resident #010's progress notes, assessments in PCC did not show any referral to the NP, Physician or RD to assess the resident's hydration status until the day prior to their transfer to hospital, when RN #114 referred to the NP to assess the resident related to complaints of pain and lower than recommended fluid intake.

In an interview, NP #114 indicated they had not been made aware of resident #010's low fluid intake prior to assessing and transferring the resident to hospital on the above identified date. NP #114 indicated that on that day resident #010 began to experience symptoms of illness, and complained of worsening pain and at that point it was decided to send the resident to hospital for further treatment. NP #114 indicated that resident #010's hydration status was potentially more fragile related to their identified diagnoses and required closer monitoring by staff. NP #114 indicated that if resident #010's fluid intake was low for one day staff were to push fluids and if they continue the following day to have low intake staff should refer to NP, MD and or RD for assessment and treatment.

In an interview, RD #122 indicated that registered staff were to monitor the daily fluid intakes for residents and use professional judgement in assessing the resident hydration status looking at the resident's condition and any signs or symptoms. RD #122 indicated that for resident #010 who had an identified minimum fluid requirement related to their identified medical diagnoses, staff should monitor and assess the resident and if not meeting the minimum fluid intake over three days, refer to the NP, Physician and/or RD to assess. RD #122 indicated that no referrals were initiated by registered staff prior to their hospitalization related to low fluid intake for resident #010 despite not meeting the daily minimum fluid requirement on 11 of the 12 above identified dates.

In an interview, the DOC indicated that registered staff were expected to review resident 24-hour fluid intakes for their assigned unit and when the resident is below their fluid recommendation staff should encourage fluid intake and monitor. The DOC indicated that if the resident was below their fluid requirement for three days then registered staff would refer to the NP, MD and RD. The DOC indicated that the registered staff should have noted resident #010's fluid intake less than their identified minimum daily fluid requirement sooner and had not referred the resident to the interdisciplinary team for assessment of their hydration status. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #010 was provided to the resident as specified in the plan.

Review of resident #010's plan of care showed dietary interventions were in place to manage the resident's nutrition and hydration risks which included a specified diet order, modified texture and fluid consistency. Individualized interventions were also in place to manage resident #010's nutrition and hydration risks including to serve an identified type of bread only.

Observation by the inspector of an identified meal service on an identified date showed resident #010 was presented with choice of entrees and chose a specified sandwich and salad entree. Dietary Aide #106 served resident #010 the sandwich which was not prepared on the above mentioned identified type of bread.

In an interview, DA #106 indicated that they were aware resident #010 was to be served only the above identified type of bread, and may have forgotten to serve their sandwich on the identified bread. DA #106 indicated that the special instructions for resident diets are documented in a binder in the servery and the identified bread was available and usually served resident #010 as indicated in the diet list.

In an interview, FSM #105 indicated that Dietary Aides should follow the diet lists available in the servery, and that DA #106 was familiar with the resident and might have been nervous and forgotten to serve resident #010's sandwich on identified type of bread.

In an interview, RD #122 indicated that resident #010 had an individualized plan in place to manage their risks for nutrition and hydration. RD #122 indicated that resident #010 was receiving the above specified diet and had specific interventions to reduce an

identified micronutrient in their diet related to an identified medical diagnosis. RD #122 indicated that serving resident #010 the identified type of bread only was an intervention to reduce the identified micronutrient in the diet, as well as a preference. RD #122 indicated that as DA #106 served resident #010 a sandwich which was not on the identified type of bread that the care was not provided to the resident as per the plan of care. [s. 6. (7)]

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 with ensuring that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

As required by Regulation O. Reg. 79/10, s. 114. (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to

ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Review of resident #010's medical directives e-MAR showed two orders for by mouth (PO) analgesic medications:
- 1 – 2 tablets of an identified medication and dosage every six hours when needed for pain and fever; and
- 1 – 2 tablets of the same identified medication at a different identified dosage every four hours as needed.

Review of resident #010's progress notes showed on an identified date, RPN #121 documented at an identified time administration of 1 – 2 tablets of the identified medication at the second above identified dosage. The progress note did not indicate the number of tablets administered, nor the effectiveness of the medication. Further review of resident #010's progress notes showed on a second identified date, RN #121 documented at an identified time administration of 1-2 tablets of the identified medication at the first identifed dosage. The progress note did not indicate the number of tablets administered, nor the effectiveness of the medication. RN #121 was not available for interview at the time of inspection. Resident #010's progress notes additionally showed RN #112 documented on a third identified date, that the resident complained of pain and administration of as needed (PRN) 2 tablets of the above identified medication with no dosage identified with effect.

Review of resident #010's medical directives e-MAR did not show documentation of the above listed medication administrations on the three above identified dates.

In an interview, RN #112 indicated that the process in the home for administration of PRN medications was for registered staff to document under a pain progress note the resident's pain type, location, intensity and effectiveness of the intervention. RN #112 indicated the administration of PRN medication should also be documented at the time of administration in the e-MAR.

In an interview, the DOC indicated that the expectation of registered staff when administering a PRN medication to treat pain for a resident would be to document in the progress notes as well as in the e-MAR. The registered staff were expected to document on the dosage of medication administered and the effectiveness of the intervention. The DOC indicated that as the administration of the identified medication was not documented in resident #010's e-Mar for the administrations on the three above

identified dates, the staff had not complied with the home's medication administration policy. [s. 8. (1) (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 with ensuring that the written policies and protocols developed for the medication management system required under O. Reg. 79/10, s. 114. (2) are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug was administered to resident #010 in accordance with directions for use specified by the prescriber.

Review of the written complaint letter from resident #010's family member showed that it was reported to resident #010's family member by staff of the home that on an identified date, an incorrect dosage of a specified medication was administered to resident #010.

Review of resident #010's Digital Prescriber's Orders form showed an order written 36 days earlier, by NP #113 discontinuing the above specified medication at an identified dosage, and ordering the same specified medication via an identified route and at an identified dosage once weekly for three months. Review of resident #010's electronic medication administration record (eMAR) showed documentation that the above identified medication was administered at the new dosage on the above mentioned identified date for the medication pass at an identified time by agency RPN #115.

Review of progress notes showed RPN #115 documented they had administered resident #010 the available dose of the above identified medication at the discontinued dosage, as the new identified dosage was unavailable. Progress notes further showed RPN #115 notified NM #119 of the incorrect dosage being administered who notified resident #010's power of attorney (POA) for care, NP #113 and the resident's physician.

Review of Medical Pharmacies medication incident report showed an incorrect dosage of the above identified medication was administered to resident #010 on the above identified date. The report showed RPN #115 could not find the new dosage of the medication, and asked an RN to locate the medication. RPN #115 was provided a dose of the specified medication at the discontinued dose and administered the medication to the resident.

In an interview, the DOC indicated that when the dosage of the above identified medication was changed, the remaining supply of the medication at the discontinued dosage should have been removed from the fridge on the unit to prevent administration error. The DOC further indicated it was the expectation of the home for registered staff to confirm the correct medication and dosage are verified against the eMAR before administering to a resident. The DOC confirmed that the incorrect dosage of the identified medication was administered to resident #010 on the above identified date. [s. 131. (2)]

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 with ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 26th day of July, 2019

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

Original report signed by the inspector.