Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Oct 9, 2019	2019_630589_0020	015441-19, 015774-19	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

JOANNE ZAHUR (589)

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): September 17, 19, 20, 24, 25, 26, 27, & 30, 2019, on-site and October 1, 2, & 3, 2019, off-site.

The following intakes were inspected during this inspection:
-Log #015774-19 related to transfers and medication management, and
-Log #015441-19 related to maintenance services, plan of care and prevention of abuse and neglect.

Written Notification with Voluntary Plans of Correction related to O. Reg., 79/10, r. 36, identified in this inspection report related to resident #002, will be issued in report #2019_630589_0022.

During the course of the inspection, the inspector(s) spoke with Executive Director/Chief Executive Officer (ED/CEO), Director of Care (DOC), Nurse Managers (NM), Director of Environmental Services (DES), Social Services Coordinator (SSC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Worker (MW), Service Manager for Handi-Care contractor (SM-HC), Substitute Decision Makers (SDM) and Residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident and room observations, and the provision of care, reviewed health records, the Long Term Care Homes (LTCH) internal investigation notes, relevant annual program evaluations, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Medication
Personal Support Services
Skin and Wound Care

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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

The licensee has failed to ensure resident #003’s SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Director related to concerns that the SDM had not been informed of the initiation of a treatment.

A review of resident 003’s health record indicated that the treatment had been ordered on an identified date in July, 2019. A review of the progress notes did not indicate any entry that resident #003’s SDM had been notified. An email to the LTCH’s management from staff #105 indicated they had made two attempts to notify resident #003’s SDM with no success however, they recalled leaving a message on their second attempt. Staff #105 stated, they had not documented these attempts in the progress notes nor endorsed to the oncoming shift so that they could have followed-up with the SDM.

During a phone call with the inspector, the complainant stated they had not been notified and did not recall receiving any phone messages from the LTCH and only found out about the treatment order when they visited resident #003, 11 days later.

In an interview, staff #103 and staff #100 both stated that resident's SDM can be difficult to contact. Both acknowledged that the SDM had not been provided the opportunity to participate fully in the development and implementation of the plan of care for resident #003. [s. 6. (5)]

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 ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the ceiling lift in resident #003's room was maintained in a safe condition and in a good state of repair.

A complaint was submitted to the Director where the complainant indicated the mechanical lift in resident #003's room was not in a good state of repair and that they were concerned for the resident's safety. The complainant alleged that a part of the mechanical lift was inches away from the resident. The complainant also indicated that staff #125 had informed them the operation of the mechanical lift was not compromised and that a service work order had been submitted.

A review of a photograph taken by the complainant and reviewed by the inspector indicated the mechanical lift part was resting on the cross bar and the inspector noted three pieces of silver tape affixed to it indicating it had been previously taped back in

place. A previous work order from four months prior indicated the mechanical lift had required service. On-site observations conducted by the inspector during this inspection indicated black tape on either end of the mechanical lift holding the part in place.

During a phone conversation with the LTCH’s service provider, they stated that identified parts may need to be tightened and if need be, the part can be replaced. The service manager further stated the LTCH has a service agreement with them that includes annual preventative maintenance and that the use of tape would be a temporary fix.

During an interview, staff #125 stated they had not submitted a work order on an identified date in August 2019, as they had not been working that day however, that it was actually submitted two days later when they were working. Staff #125 did acknowledge telling the complainant that the function of the mechanical lift was not impaired even though the part was not in place and for this reason they had not tagged the mechanical lift out of service.

During an interview, staff #103 acknowledged that they had submitted another work order, one day after staff #125 had.

During an interview, staff #119 was able to provide work orders for the above two mentioned dates and stated they had used an identified type of black tape to hold the part in place. Staff #119 further stated that the service contractor had not been called as they had just repaired it on their own. Staff #119 also acknowledged that the mechanical lift should have been tagged out of service as it was not in a safe condition and in a good state of repair.

During an interview, staff #100 acknowledged that the safety of residents always comes first and for that reason the mechanical lift in resident #003’s room should have been tagged out of service as it was not in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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 home's equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

The licensee has failed to ensure that resident #003 received finger nail care, including the cutting of fingernails.

A complaint was submitted to the Director related to care concerns for resident #003. The complaint further indicated that a staff member had informed the complainant that resident #003 exhibited responsive behaviours when staff attempted to provide this care.

An observation conducted by the inspector indicated that an identified finger nail was long and pressing against an identified area of the hand. This observation was brought to the attention of staff #111 who stated it was the responsibility of the PSW staff to provide this care.

Interviews with PSW staff working on the resident home area (RHA) indicated that they are responsible for this task but that resident #003 exhibits responsive behaviours most of the time and that the registered staff are aware.

A further review of the care plan indicated that on an identified date during the inspection, staff #103 had updated the care plan as follows:

-Protect Resident feet from injury; avoid using heating pads, constrictive shoes or socks, sharp implements near feet. Also, Toe nails will be trimmed by foot care nurse and finger nails will be trimmed by one registered staff and one direct care staff.

Staff #103 confirmed they had made this update to provide clearer direction to staff as when they reviewed the care plan, they realized this focus had not been addressed clearly.

During an interview, staff #111 stated they were not aware of the above-mentioned direction related to nail care for resident #003 until informed by the inspector.

During an interview, staff #103 acknowledged they had told staff verbally when seen in the nursing station and was going to prepare a notice for staff to read and acknowledge the above-mentioned care changes for resident #003. [s. 35. (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 to ensure that each resident receive finger nail care, including the cutting of fingernails, to be implemented voluntarily.

Issued on this 10th day of October, 2019

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

Original report signed by the inspector.