Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 4, 2020	2020_630589_0001	017301-19, 018478-19, 019712-19, 019841-19	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

JOANNE ZAHUR (589)

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): January 8, 9, 13, 14, 15, 16, & 17, 2020.

During this inspection the following were inspected:
Log #019712-19 related to compliance order #001, r. 36, improper transferring and positioning techniques, and
Logs #019841-19/Critical Incident System (CIS) #C579-000024-19, #018478-19/CIS#C579-000023-29, and 017301-19/CIS #C579-000021-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer/Executive Director (CEO/ED), Director of Care (DOC), Nurse Managers (NM), Physiotherapist (PT), Physician, Personal Support Workers (PSW), Registered Staff (RN/RPN), Behavioural Support Lead (BSL), and Residents.

During the course of the inspection, the inspector observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed health records, staff training records, compliance plan records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 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
O.Reg 79/10 s. 36.	CO #001	2019_630589_0022	589

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. (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 :

The licensee has failed to ensure the care set out in the plan of care was provided to resident #003 as specified in the plan.

A critical incident system (CIS) report was submitted to the Director involving resident #003. The CIS report indicated that a review of camera footage indicated resident #003 had an incident that resulted in a transfer to hospital for further assessment of a possible injury.

A review of resident #003's health record indicated that they were independent with ambulation however staff were not to allow the resident to ambulate without their assistive aid and to reinforce the use of it. The health record also indicated they were at risk for falls and associated interventions included the following:
-encourage resident to use the handrails or assistive devices properly,
-ensure protective devices are in place, resident takes them off as refuses to wear them, and
-resident forgets to use their assistive aid and needs constant reminders.

During an interview, staff #113 stated that after providing care to resident #003 they had walked them down the hallway and left them sitting in a chair located near the resident's room. Staff #113 also stated they were not aware of the use of an assistive aid or protective devices.

A review of the kardex which is located in the point of care (POC) screen indicated the use of an assistive aid for ambulation and the use of protective devices. The kardex indicate individual resident activities of daily living (ADL) care needs and are accessed by PSWs.

During an interview, staff #108 stated that after viewing camera footage of the above

mentioned incident, they observed resident #003 ambulating alone without an assistive aid around the corner from the back hallway towards their room holding the handrail. Staff #108 then observed resident #003 stop and when turning, they lost their balance and fell. Staff #108 stated they did not observe staff #113 in this camera footage at any point guiding or assisting the resident with walking. The camera footage was not saved; therefore it was not available for the inspector to view at the time of this inspection.

During a follow-up conversation, staff #113 continued to state they had walked resident #003 from the shower room down the hallway and left them sitting in a chair, even though the camera footage did not indicate this. Also, during a follow-up conversation, staff #108 verified they had not observed staff #113 walking with resident #003 on the camera footage, and that the resident had been walking alone down the hallway.

Staff #108 acknowledged that staff #113 had not provided care to resident #003 as per their 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 to ensure the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #001.

A CIS report was submitted to the Director which indicated an incident had occurred involving resident #001. The CIS report indicated that the resident had gone to the toilet on their own, however the resident stated the PSW had transferred them. As per resident

#001 they did not strike their head and had slipped from the toilet, not fallen. No injuries were noted.

A review of resident #001's health record indicated that staff are not to leave the resident unattended during care and to use an identified mechanical lift. Staff are to use an alternate mechanical lift if the resident is unable to transfer with the identified mechanical lift. A further review of the health record indicated that resident #001 had no memory problems, however during a conversation between resident #001 and the inspector, they could not recall the above-mentioned incident clearly.

A review of camera footage still photos indicated that between identified time frames, the PSW, resident #001 and the family member were observed. These observations indicated that no other PSW was present when care was being provided. A further review of the camera footage still photos indicated the family member leaving and approximately 12 minutes later, additional staff approaching and entering resident #001's room bringing with them a mechanical lift and vital sign equipment.

During an interview, staff #111 stated that when they had called resident #001's family member to inform them of the incident, they stated that they had just left the LTCH and had seen the PSW transfer the resident and asking how could this have happened. Staff #111 further stated to the inspector that the identified PSW had told them that resident #001 had transferred themselves independently. As a result of conflicting stories about what had happened, staff #111 notified staff #108 to further investigate.

A review of the long-term care home's (LTCH) investigation notes indicated that during an interview with the identified PSW, they denied transferring resident #001 alone but stated that the resident had self transferred. The inspector did not conduct an interview with the identified PSW as they are no longer employed by the LTCH. A review of the LTCHs internal investigation notes indicated that the PSW denied transferring resident #001 alone even though the camera footage showed they had, and that their mobility aid had been left in the passage between the washroom and room doorways. The notes further indicated that the LTCH concluded that the PSW had left the resident unattended during care. The LTCH's interview notes with the PSW indicated, they acknowledged knowing that resident #001 required a mechanical lift with two staff present when transferring.

During an interview, staff #100 acknowledged that the identified PSW had not provided care to resident #001 as per their plan of care and therefore used an unsafe transferring

technique.

This finding is additional evidence related to compliance order #001, O. Reg 79/10, s. 36 served under report #2019_630589_0022 with a compliance date of January 6, 2020, that was complied. [s. 36.]

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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the written report to the Director included long-term actions to prevent recurrence.

A CIS report was submitted to the Director related to an incident involving resident #005. The CIS report indicated that the resident had an incident in the washroom located within their room. A review of the CIS report indicated that long-term interventions moving forward to prevent recurrence was pending as resident #005 remained in hospital.

A review of the long-term care portal for CIS reports indicated that long-term interventions to prevent recurrence had not been added upon their readmission to the LTCH.

During an interview, staff #103 acknowledged that the CIS report had not included long-term care interventions to prevent recurrence. [s. 107. (4) 4.]

Issued on this 6th day of February, 2020

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

Original report signed by the inspector.