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
Jan 5, 2022	2021_769646_0023	018141-21, 019355-21	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

IVY LAM (646)

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): December 1, 2, and 3, 2021.

The following Complaint intakes were completed during this inspection:
- Log #018141-21 related to allegations of neglect, personal support services, and hospitalization and change in condition, and
- Log #019355-21 related to reporting and complaints.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) - Coordinator, Director of Environmental Services, Physiotherapist (PT), Physiotherapist Assistant (PTA), Family Members, Substitute Decision Maker (SDM), and Residents.

During the course of the inspection, the inspector observed staff to resident interactions, reviewed residents' clinical records, staffing schedules, pertinent policies and procedures, and observed IPAC practices.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care set out clear directions to staff and others who provided direct care to the resident.

A resident was transferred to the hospital and a medical condition was identified for the resident at the hospital.

The resident's most current care plan indicated the resident used a Personal Assistance Service Device (PASD) when they were in bed, and staff were to check and change the resident, but the care plan did not indicate how many staff members were needed to change the resident.

Record review showed that prior to the medical condition, staff provided care with one staff to the resident for bed mobility and continence care. After the condition, staff provided care with one staff on day shift and two staff on evening shift.

Multiple observations of the resident by the inspector during the inspection showed the resident's PASDs were provided for the resident while the resident was in bed. A Personal Support Worker was observed to provide continence care for the resident on their own. The PSW indicated the resident had not been able to use the PASD for

several months and had declined in their mobility.

Another PSW indicated the resident was able to use their PASD prior to their hospitalization, but was no longer able to use it after their return to the home. The PSW indicated that since the medical condition, they would call a second staff to assist with identified care for the resident.

A Registered Practical Nurse (RPN) indicated they were new on the unit and was not aware of the resident's hospitalization and subsequent medical condition. The RPN reviewed the resident's care plan and indicated it was unclear how many staff the resident required for assistance with identified care areas.

The Physiotherapist (PT) indicated the identified PASDs for residents who were able to use them. The PT's assessment of the resident during the time of the inspection, indicated the resident was not able to use their PASD and that they had declined since the PT's last assessment. The PT indicated that the resident may require more than one staff for assistance with identified care for the resident's safety, as they were no longer able to participate in their own care. Upon review of the care plan, the PT indicated they were not sure what the current directions were regarding how many staff were required for the resident's identified care care, and it would be good for the nursing team to clarify.

The Director of Care (DOC) indicated the resident would be reassessed by the interdisciplinary team so that clear directions would be provided for staff.

There was a risk that the resident would not be provided with the level of assistance they needed for their identified care, when the resident's care plan did not provide clear direction. The PSWs provided different care and the registered staff and PT were not aware what level of assistance the resident needed in those areas.

[Sources: Review of: Resident's Minimum Data Set (MDS), Documentation Survey Reports, current Care Plan with revision history, progress notes; Observations of: Resident, resident's room environment, provision of care for resident; Interviews with the Resident, PSWs, RPN, PT, DOC, and other staff.] [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects

of care collaborated with each other in the assessment a resident, so that their assessments were integrated, consistent with and complemented each other.

A resident was found to have signs related to a health condition by an RPN, and the resident was transferred to hospital, where they were diagnosed with the health condition.

After the incident, the resident's diet and fluids were changed.

During the home's investigation, a PSW indicated that on the previous day, at the end of their shift, they had noted a sign during conversation with the resident. The resident's roommate's visitors also indicated to the PSW that the resident did not look good that day. The PSW had planned to report this occurrence to the registered staff but had forgotten until the registered staff spoke with them the next day.

The day and evening RPNs and the evening PSWs who worked on the shift on the previous day indicated they did not notice anything out of the ordinary for the resident during their interactions with the resident that day.

The PT was referred by an RPN to assess the resident four days after the resident's return to LTC. The DOC indicated the PT had assessed the resident related to their condition on the fifth day after the resident's return to the home, and indicated no new updates compared to last quarter.

The PT indicated they were not aware the resident had the identified medical condition until they spoke to the inspector. There was no information on the above-mentioned PT referral regarding the request for assessment. The PT indicated there was no change to the resident's transfer needs, but did not assess the resident related to changes in care needs related to their medical condition. They further indicated they could have clarified with the nurse who sent the PT referral about the reason for the referral, but they had not done so.

The PT assessed the resident during the time of inspection and identified the resident's ability was impacted by the medical condition. This would affect their ability to use their PASD and would affect their ability participate in their care. They further indicated the resident would be safer with a higher level of assistance with more staff when providing identified care for the resident, but that this would be for the nursing team to determine, and the PT would provide the assessment on the resident's ability.

The PT indicated that the resident would benefit from the PT's assessment after their hospitalization and medial diagnosis, so the home could clarify the resident's needs and provision of care by the registered staff and PSWs.

The DOC indicated that the registered staff should have indicated the reason for the PT referral after the resident's medical diagnosis so that the staff could collaborate in the assessment of the resident.

The lack of collaboration between the PSWs, registered staff, and PT puts the resident at risk of not receiving timely, integrated, and consistent assessment of their medical diagnosis and care after return from hospital.

[Sources: Record review of hospital inpatient consults, Home's Internal Complaint Documentation Form, Resident's progress notes, Resident's Documentation Survey Reports v2; Observations of resident, resident's room environment, and staff and resident interactions; Interviews with PSW, RPN, PT, DOC, and other staff.] [s. 6. (4) (a)]

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 written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, and 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.

Issued on this 10th day of January, 2022

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

Original report signed by the inspector.