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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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5700, rue Yonge 5e étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2021	2021_938758_0003	011909-21	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

NOREEN FREDERICK (704758)

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): November 8, 9, 10, 12 and 15, 2021.

The following Critical Incident System (CIS) intake was completed during this CIS inspection:

Log #011909-21 related to improper or incompetent treatment or care of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Manager (NM), Registered Nurse (RN), Personal Support Workers (PSWs), and Housekeeper.

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:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **1 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. 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 :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when transferring a resident from an assistive device to the bed.

The home submitted a Critical Incident System (CIS) report related to a resident's fall while being assisted with transferring, that resulted in an injury.

The resident’s care plan indicated that they required the use of a mechanical lift for transfers.

According to Personal Support Worker (PSW) #100, they did not double check the sling attachments to the mechanical lift properly. PSW #101 indicated they did not do a safety check to ensure that the resident’s sling attachments were applied and attached correctly. As a result, the resident fell and sustained injury.

Additionally, both above PSWs performed another unsafe transfer after the resident’s fall. They physically transferred the resident from floor to an assistive device without use of any transferring devices and prior to an assessment by registered staff. Both PSWs were aware that their actions did not comply with the home’s policy.

Nurse Manager (NM) #103 acknowledged that unsafe transferring and positioning techniques were used by PSW #100 and PSW #101 while assisting the resident.

Sources: resident’s health records, home’s investigation notes, interviews with PSW #100, PSW #101, and NM #103.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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 when a resident had a witnessed fall with injury, the home's fall prevention policy was complied with, in respect of completing a head to toe assessment by a registered staff prior to transferring a resident from the floor.

Ontario Regulation (O. Reg) 79/10, s. 48 (1) 1 requires that an interdisciplinary falls prevention and management program is developed and implemented in the home to reduce the incident of fall and risk of injury.

O. Reg. 79/10, s. 49 (2) requires the resident to be assessed after their fall.

Specifically, staff did not comply with the home’s head to toe assessment by a registered staff strategy within their Fall Prevention and Management Program policy.

The home’s head to toe assessment strategy required that, staff witnessing a fall should not move the resident if there is a suspicion or evidence of injury until a full head to toe assessment has been conducted and appropriate action determined.

On an identified day, a resident fell while being assisted by PSWs #100 and #101, sustaining injury. In this incident, involved PSWs transferred the resident after their fall from the floor without a head to toe assessment by a registered staff. As a result, there was risk of further injury to the resident.

NM #103 acknowledged that both PSWs involved in above incident transferred the resident from floor to an assistive after their fall without a head to toe assessment by registered staff.

Sources: resident’s health records, home’s investigation notes, home’s Fall Prevention and Management Program policy (#F-30 revised 11/09/2018), interviews with PSW #100, PSW #101, and NM #103.

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 plan, policy, protocol, procedure, strategy or system in place is complied with, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's planned care related to sling size was set out in their written plan of care.

The resident 's care plan indicated a different size sling prior to and after a fall incident than the size resident was using.

According to the home's Mobility and Minimal Lift Program policy- appendix F-sling reference chart and resident's monthly weight report for 2021, the resident should have used a smaller sling than what was indicated in their plan of care.

According to Registered Nurse (RN) #108, the resident's care plan indicated a larger size sling than the resident used prior to and after the fall incident. They admitted to changing the sling size to the correct size in the care plan during the inspection. They stated that sling sizes were based on a residents' weight, and according to this resident's weight, sling size should have been revised in the care plan but was overlooked.

NM #103 and Director of Care (DOC) verified that the sling size indicated in the care plan was not the correct size according to the planned care for the resident.

Sources: resident's health records, home's Mobility and Minimal Lift Program policy (#F-20, revised 11/01/2021), interviews with PSW #100, PSW #101, RN #108, NM #103, and DOC.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately when the home suspected improper care of a resident by staff who used unsafe transferring and positioning techniques when transferring the resident.

The home submitted an after-hours report approximately 24 hours after the incident and submitted a CIS report another 24 hours later, related to the resident's fall during their transfer that resulted in an injury.

The resident's care plan indicated that they required the use of a mechanical lift for transfers. According to PSW #100 and PSW # 101, they did not double check if the sling was locked to the mechanical lift properly. As a result of unsafe transferring techniques, the resident sustained a fall with injury.

NM #103 acknowledged that based on their investigation of above incident, they determined the same day as the incident occurred, that incompetent care was provided to the resident. The suspicion of improper or incompetent care was not immediately reported to the Director as required.

Sources: resident's health records, critical incident report (CIS) # 3021-000004-21, interviews with NM #103 and other staff.

Issued on this 9th day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	NOREEN FREDERICK (704758)
Inspection No. / No de l’inspection :	2021_938758_0003
Log No. / No de registre :	011909-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 6, 2021
Licensee / Titulaire de permis :	The Wexford Residence Inc. 1860 Lawrence Avenue East, Toronto, ON, M1R-5B1
LTC Home / Foyer de SLD :	The Wexford 1860 Lawrence Avenue East, Scarborough, ON, M1R-5B1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Sandy Bassett

To The Wexford Residence Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with s. 36. of O. Reg. 79/10.

Specifically, the licensee must:

1. Retrain PSW #100 and #101 on the home's Mobility and Minimal Lift Program policy. The training should include safe transferring and positioning techniques during all aspects of resident's care. A test component to evaluate both PSW's understanding of safe transferring and positioning techniques.

2. The home must maintain a record of above education including date of education, who provided the education, signed attendance sheet for education and the content of education.

3. Conduct weekly audits of PSW #100 and #101's transfer techniques to ensure safe transfer and positioning of residents for a minimum period of four weeks or longer if further concerns are identified.

4. The home must maintain a record of above audits, including the date of observation, who completed the observation, and any corrective action.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when transferring a resident from an assistive device to the bed.

The home submitted a Critical Incident System (CIS) report related to a resident's fall while being assisted with transferring, that resulted in an injury.

The resident's care plan indicated that they required the use of a mechanical lift for transfers.

According to Personal Support Worker (PSW) #100, they did not double check the sling attachments to the mechanical lift properly. PSW #101 indicated they did not do a safety check to ensure that the resident's sling attachments were applied and attached correctly. As a result, the resident fell and sustained injury.

Additionally, both above PSWs performed another unsafe transfer after the resident's fall. They physically transferred the resident from floor to an assistive device without use of any transferring devices and prior to an assessment by registered staff. Both PSWs were aware that their actions did not comply with the home's policy.

Nurse Manager (NM) #103 acknowledged that unsafe transferring and positioning techniques were used by PSW #100 and PSW #101 while assisting the resident.

Sources: resident's health records, home's investigation notes, interviews with PSW #100, PSW #101, and NM #103.

An order was issued based on the following factors:

Severity: As a result of the incident, a resident experienced actual harm.

Scope: This issue was identified as a pattern, as the same resident was affected twice by repeated unsafe transferring techniques.

Compliance history: The licensee was previously found to be non-compliant with O. Reg. 79/10, s. 36 where two written notifications were issued including a Compliance Order (CO) and a Voluntary Plan of Correction (VPC) in the past 36 months.
(704758)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 03, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Noreen Frederick

Service Area Office /
Bureau régional de services : Toronto Service Area Office