Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 17, 2023	
Inspection Number: 2023-1515-0002	
Inspection Type: Critical Incident System	
Licensee: The Wexford Residence Inc.	
Long Term Care Home and City: The Wexford, Scarborough	
Lead Inspector Rajwinder Sehgal (741673)	**Inspector Digital Signature**
Additional Inspector(s) Maya Kuzmin (741674) Jack Shi (760) was also present during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 5-6, 9-10, 2023.

The following intake(s) were completed in this Critical Incident System (CIS) inspection:
·Intake: #00001192 (AH: IL-02073-AH/CI: 3021-000005-22) related to physical abuse to the resident by another resident.
·Intake: #00015711 (IL-08187-AH/3021-000024-22) related to improper care to the resident resulting in injury.

The following **Inspection Protocols** were used during this inspection:

Prevention of Abuse and Neglect
Responsive Behaviours
Infection Prevention and Control
Resident Care and Support Services

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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that fall prevention interventions were provided to a resident as specified in their plan of care.

The resident's plan of care indicated that they required a specific fall intervention.

On an identified date, the resident was observed without the intervention in place.

In an interview with Personal Support Worker (PSW), acknowledged that the resident's plan of care was not followed as they did not have the specific fall intervention on. The PSW immediately located the resident's intervention and applied it on the resident.

Sources: Observations, and interview with PSW.

Date Remedy Implemented: January 6, 2023

[741673]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

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

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Director related to resident #001's fall during a transfer that resulted in an injury.

Record review of the resident #001's plan of care indicated that the resident required a specific type of transfer.

A review of the LTCH's policy titled: Mobility and Minimal Lift Program, directed all staff to transfer residents in accordance to their care plan and logo.

In an interview with PSW #108 and PSW #109, they admitted using the incorrect transfer method for resident #001. PSW #109 stated they did not check the resident's care plan or confirmed with the regular staff if this transfer method was the correct one for the resident. As a result of the incorrect use of the transfer method, resident #001 sustained an injury.

A review of the home's internal investigation notes indicated that PSW #108 and PSW #109 did not follow the resident's plan of care and transferred resident #001 in an unsafe manner.

Director of Care (DOC) #106 acknowledged that PSW #108 and PSW #109 had not used a safe transferring technique when assisting resident #001.

There was actual harm to the resident when the safe transferring technique was not followed.

Sources: CIS report, resident's #001 clinical records and progress notes, home's investigation notes, mobility and minimal lift program policy, interviews with PSWs, DOC, and other staff.

[741673]

WRITTEN NOTIFICATION: WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that resident #002 was protected from physical abuse by resident #003.

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Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary:
On an identified date, PSW #104 was providing assistance to resident #002 when resident #003 came up to resident #002 and physically abused them.

After the incident occurred, resident #002 sustained injuries and required additional interventions following the incident.

During an interview, PSW #104 acknowledged that resident #002 and #003 should not have been in the area at the same time.

During an interview, DOC #106 acknowledged that resident #002 experienced physical abuse by resident #003.

Failure to separate resident #002 and resident #003 from a designated area, resulted in resident #003 physical abusing resident #002.

Sources: CIS report; resident #003's and resident #002's clinical records; Prevention of Abuse and Neglect Policy #6.46 (December 2022); interviews with PSW #104 and DOC #106.

[741674]

WRITTEN NOTIFICATION: WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: FLTCA, 2021, s. 6 (7) The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #003 specifically related to inappropriate behaviours.

Rationale and Summary:
A CIS report was submitted to the Director related to a physical altercation between two residents. Resident #002 sustained injuries by resident #003 and required additional interventions.

On an identified date, resident #003’s care plan interventions indicated that resident #003 will not be in a designated area at the same time with resident #002.

During an interview, PSW #104 stated that on an identified date, resident #003 physically abused resident #002.

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After the incident, PSW #104 was informed by the registered staff of the care plan interventions not to bring in resident #003 into the designated area if resident #002 was present. The inspector reviewed the care plan interventions with PSW #104, in which, they also acknowledged that these two residents should not be in the designated area at the same time.

During an interview, Behavioural Support Ontario (BSO) lead #105 stated that resident #002 and resident #003 should not be in the designated area at the same time.

During an interview, DOC #106 stated that staff would be responsible to follow the care plan interventions.

The staff’s failure to not follow the care plan interventions for resident #003 resulted in a physical injury to resident #002 by resident #003.

Sources: CIS report; resident #003's and resident #002's clinical records; interviews with PSW #104, BSO #105 and DOC #106.

[741674]