Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 22, 2024

Inspection Number: 2024-1515-0002

Inspection Type:
Critical Incident

Licensee: The Wexford Residence Inc.

Long Term Care Home and City: The Wexford, Scarborough

Lead Inspector	**Inspector Digital Signature**
Adelfa Robles (723)	Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2024.02.23 16:19:37 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-9, 2024

The following intake(s) were inspected:

- Intake Log #00099015/ (Critical Incident (CI) #3021-000027-23 – related to falls with injury.
- Intake Log #00101426/CI #3021-000029-23 – related to alleged physical abuse.

The following intake(s) were completed:

- Intake Log #00098541/CI #3021-000025-23, Intake Log #00101252/CI #3021-000028-23 and Intake Log # Intake: #00107863/CI #3021-000002-24 – were related to respiratory disease outbreaks.
- Intake Log #00102452/CI #3021-000030-23 -related to fall with injury.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality regardless of their disability.

Rationale and Summary

A complaint was reported to the home related to an alleged resident abuse. The resident had impaired cognition related to a medical diagnosis with history of responsive behaviours including resistance to care.

Video footage was provided by the home and revealed two staff providing personal care to a resident with a specific body part dangling off the bed. Staff stated that the resident's body part came off the bed when the second staff assisted during care.

Another video footage showed the second staff member take an electronic device away from the resident without informing the resident. The video also showed the staff speaking disrespectfully to the resident when the resident became verbally aggressive.

The resident did not experience any ongoing emotional distress following these incidents.

SOURCES: Video clips, home records and staff interviews.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care for a resident related to their fall intervention was provided as specified.

Rationale and Summary

A CI report was submitted by the home when a resident fell twice and sustained injuries. The resident was at risk for falls and staff were expected to ensure a specific intervention was in place.

During the inspection, the resident was observed with the above intervention not correctly applied. Staff stated that the resident required the specified intervention to protect them from injury in case of fall. The home stated that staff were expected to follow resident's plan of care as specified.

There was a risk of injury to the resident when their fall intervention was not provided as specified in the plan.

SOURCES: Resident observation, clinical records, and staff interview

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