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
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Original Public Report

Report Issue Date: July 19, 2024

Inspection Number: 2024-1515-0003

Inspection Type:
Critical Incident

Licensee: The Wexford Residence Inc.

Long Term Care Home and City: The Wexford, Scarborough

Lead Inspector	**Inspector Digital Signature**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2024.08.06 11:42:49 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20, 21, 24, 25, 27, 2024 and July 2, 3, 4, 5, 8, 9, 2024

The following intakes were inspected in the Critical Incident System (CIS) inspection:

- Intake: #00112169/CIS#3021-000008-24 related to unsafe positioning of a resident.
- Intake: #00112425/CIS#3021-000011-24 and intake: #00113687/CIS#3021-000012-24 related to disease outbreaks.
- Intake: #00118298/CIS#3021-000016-24 related to improper care of a resident.
- Intake: #00119613/CIS#3021-000018-24 related to fall of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

Plan of care

s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that when the care set out in the plan was not effective for a resident that different approaches were considered in the revision of the plan of care.

Rationale and Summary

Upon admission of a resident to the home, the resident was identified at risk for falls and falls prevention interventions were initiated.

The resident sustained two falls and their plan of care was not revised related to

falls. On an identified date, the resident had another fall and was transferred to the hospital. The resident died five days after their fall and their cause of death was fall related injury.

The home's policy titled "Fall Prevention and Management program" indicated to monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team and if the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary.

Between the residents three fall incidents, different approaches were not considered or implemented to reduce the resident's risk of falling and risk of injuries as result of falls. The Assistant Director of Care (ADOC) indicated that the home should have tried alternative interventions when falls interventions set out in the resident's care plan were not effective.

Failure to consider alternative approaches when the resident's fall interventions were ineffective increased the risk of the resident's falls and fall related injuries.

Sources: Resident's clinical records, home's policy titled "Fall Prevention and Management Program" index #F-30 last revised May 2024, interviews with Registered Nurse (RN) and ADOC.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from an incident of neglect by staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
A CIS report was submitted to the Director related to a resident's fall which caused an injury for which the resident was taken to hospital and resulted in their death.

A Personal Support Worker (PSW) stated they found the resident on the floor by the bed. The PSW reported this to the Registered Practical Nurse (RPN), the RPN completed head to toe assessment and took resident's vitals. The resident complained of pain and had sustained an injury. Later, during that shift the RPN completed additional pain assessments and the resident complained of pain. PSW #114 and PSW #115, both confirmed that the resident complained of severe pain after their fall and later during the shift when they provided care to the resident. The Medical Director (MD) was not immediately notified of the resident's severe pain and was left a note to assess later. There was no treatment provided to the resident related to pain until approximately second and half hours after their fall.

The resident was assessed by the day RN, who noted that the resident was in severe pain, and that there had been a change in their condition. The resident was immediately sent to the hospital, diagnosed with injury and died five days after their fall. Their cause of death was injury related to the fall.

The RPN, the RN and ADOC all acknowledged that the resident should have been sent to the hospital immediately after the fall for further assessment and treatment related to the pain and injury. The RN and ADOC both acknowledged that night registered staff failed to provide the resident with the treatment, care, services or assistance required for their health, safety and well-being.

As a result of the inaction, the resident's health and well-being was jeopardized causing delay in the resident receiving the proper treatment and medical care.

Sources: CIS report, internal investigation notes, resident's clinical records, interviews with the PSW #114, #115, RPN, RN and ADOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe positioning techniques when assisting the resident.

Rationale and Summary
A CIS report was submitted to the Director related to an incident that caused an injury to the resident for which they were taken to the hospital.

The resident was dependent on a wheelchair and required specific staff assistance for locomotion on and off unit. The resident's progress notes indicated that the PSW was transferring the resident back to their room when they bumped the resident's wheelchair into the room door. Upon assessment by the RPN, an injury was noted, and the resident was transferred to the hospital.

A review of the home's internal investigation notes indicated that the resident's feet were not positioned flat on footrests when the PSW portered the resident.

The PSW acknowledged that they failed to position the resident's feet flat on footrests. The ADOC acknowledged that resident's feet were not in a safe position and the PSW had not used safe positioning techniques when assisting the resident.

There was injury to the resident when the staff failed to ensure that the resident's feet were in a safe position while porting them in their wheelchair.

Sources: CIS report, resident's clinical records, home's investigation notes, interviews with PSW, RPN, RN and ADOC.

WRITTEN NOTIFICATION: Maintenance services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that a resident's wheelchair was kept in a good repair.

Rationale and Summary
A resident sustained an injury and was transferred to the hospital for further assessment. Record review of the resident's progress notes indicated that the resident's Power of Attorney (POA) reported that there was a defect in the resident's wheelchair when they visited the resident. The home's investigation notes indicated that possible cause of the injury could have been related to the wheelchair's defect.

The RN stated that there was a sharp metal part sticking out from the right-side arm rest when they checked the wheelchair after being notified by the resident's POA. The ADOC and the Physiotherapist, both acknowledged that the wheelchair was not in a good repair and was not safe for the resident to use.

Failure to ensure that the resident's wheelchair was in a good state of repair put them at risk of injury.

Sources: Resident's clinical records, CIS report, interviews with RN, ADOC and Physiotherapist.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Specifically, Sections 9.1, "the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program", including the four moments of hand hygiene.

Rationale and Summary
i) During a dining service on the second floor, a PSW was observed portering a wheelchair-dependent resident to the dining room for meal service. After seating the resident at their designated table, the PSW left the dining room and entered into resident's room and interacted with multiple surfaces in the room, without having completed hand hygiene. Later, the same staff failed to perform hand hygiene before entering another resident's room and did not perform hand hygiene prior to donning gloves before resident care.

The PSW acknowledged that they did not perform hand hygiene before and after coming into contact with a resident or resident's environment.

Failure to perform hand hygiene before/after initial resident/resident environment placed the resident at increased risk for transmission of infection.

ii) During a dining service on the second floor, a PSW was observed portering a wheelchair-dependent resident to the dining room for a meal service. The resident was not assisted to perform hand hygiene prior to the meal service.

The PSW acknowledged that they missed assisting the resident with hand hygiene prior to lunch.

When staff did not support resident to perform hand hygiene prior to meals, it increased the risk of possible disease transmission.

Sources: Dining observation, IPAC Standard for LTCH's last revised April 2022, home's hand hygiene policy and procedure last revised on May 2024, interviews with PSW and ADOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that symptoms indicating the presence of infection for a resident were monitored and recorded on every shift.

Rationale and Summary
A resident had respiratory symptoms and was placed on additional precautions. Later, the resident was tested positive for the infection.

The resident's progress notes indicated that staff failed to monitor and record signs and symptoms of the infection when the resident was symptomatic on two identified shifts.

The ADOC verified that when a resident has symptoms of an infection, staff are to monitor the resident, and document the symptoms in a progress note on every shift. The ADOC acknowledged staff did not document on each shift when the resident was symptomatic of the infection.

Failure to monitor the resident's infection placed them at risk for inadequate treatment and delayed recovery.

Sources: Resident's progress notes, and interview with ADOC.