Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 29, 30, 31, Sep 4, 6, 7, 10, 11, 12, 14, 28, Oct 4, 5, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 2012	2012_048175_0012	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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director, Executive Director, Director of Care (DOC), Nurse Manager, Registered Dietitian (RD),1 Registered Nurse(RN),3 Registered Practical Nurses(RPN), 5 Personal Support Workers(PSW), and 4 residents.

During the course of the inspection, the inspector(s) reviewed resident health care records specific to the complaints, observed staff:resident interactions specific to the complaints on Resident Home Areas, reviewed home's policies and procedures specific to the complaints, reviewed Critical Incident Reports specific to the complaints, reviewed Summary of Complaints from January to June 2012,reviewed Complaints Log Sheet for August 2012, Responsibilities of the Wexford Residence to Family Members and Responsibilities of Families to the Wexford Residence per the home's Mission Statement Values of the Wexford.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Nutrition and Hydration

Pain

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

Snack Observation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(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 failed to ensure that there is a written plan of care for each resident that sets out clear directions for staff and others who provide direct care to the resident, related to continence.[Ref. LTCHA 2007, c.8. s6(1)(c)].

Resident #8's care plan was reviewed October 16, 2012 and indicated under toileting that the resident requires assist to restore function to maximum self sufficiency. Goal is that resident will ask for and receive the necessary assistance. Interventions related to toileting did not provide clear directions to staff on how to assist the resident to restore function to maximum sufficiency.
Interview with RN October 16, 2012 @ 11:15 hrs confirmed that resident #8 does not receive assistance and support from staff to become continent or continent some of the time.

2. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions for staff and others who provide direct care to the residents, related to changes in health status.[Ref.LTCHA 2007, c.8. s6(1)(c)].

Resident #2's Care Plan was reviewed under transferring and indicated that the resident can weight bear and requires two staff to move from one position to another. The resident can weight bear, but is being transferred via ceiling lift due to pain and swelling related to known changes to health status. There was no plan of care documented related to the pain and swelling.

Multidisciplinary Progress Notes were reviewed and indicated resident # 2 was identified with swelling, and intermittent pain. Physician orders and Physio interventions confirmed resident #2 had pain and swelling.

3. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions for staff and others who provide direct care to the resident, related to nutritional care.[Ref. LTCHA 2007, c.8. s6(1)(c)].

Resident #2's Nutritional Care Plan was reviewed August 31,2012, and indicated that the resident, is a high nutritional priority, and requires assistance to eat and has dentures. There was no clear direction to staff and others who provide direct care to the resident related to dentures and nutritional care.

Interview with a staff member September 11, 2012 @ 11:37 hours indicated which diet texture the resident was to receive related to denture status.

Interview with RPN September 10, 2012 @ 10:36 hours confirmed that Resident#2's written plan of care does not provide clear directions to staff and others who provide direct care to the resident related current problems with resident dentures and the potential impact on the resident's nutritional care.

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident related to continence, changes in health status and nutritional care., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time. [Ref. Reg 79/10 s. 51(2)(d)].

2.Resident #8's care plan was reviewed October 16, 2012 and indicated that the resident requires assist to restore function to maximum self sufficiency. Goal is that resident will ask for and receive the necessary assistance. Interventions include total assist of two persons.

3.Interview with RN on an identified Resident Home Area, October 16, 2012 @ 11:15 hrs confirmed that resident #8 frequently does not receive assistance and support from staff to become continent or continent some of the time.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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 recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with dignity and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.[Ref. LTCHA, 2007 c.8 s.3(1)1].

2.A review of a written complaint with the DOC, on October 16, 2012, indicated that an abuse complaint was received alleging that a staff was observed with resident #9 1)rushing the breakfast meal by shoving too much food into the resident's mouth , 2)yelling loudly at the resident, and the same staff member was observed to swing the resident's wheelchair around very fast and pulled the resident backwards into the room and then the staff member slammed the resident's door shut.

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 following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every verbal or written complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately [Ref. Reg 79/10 s. 101(1)1].

A written complaint was reviewed by the DOC, alleging an observation of staff member abuse of resident #9 by 1) rushing the breakfast meal by shoving too much food into the resident's mouth , 2)yelling loudly at the resident, and the same staff member was observed to swing the resident's wheelchair around very fast and pulled the resident backwards into the room and then the staff member slammed the resident's door shut.

Interview of the DOC October 16, 2012 indicated that a meeting was held by the DOC with all the staff working on the identified Resident Home Area to discuss the above allegation of staff to resident abuse. The DOC confirmed there was no further action taken or a resolution provided.

Interview with RN on an identified Resident Home Area, October 16, 2012 @ 11:15 hrs indicated the resident#8 can and does communicate with staff and there have been verbal complaints expressed by the resident to the staff concerning the resident having to frequently wait too long to receive staff help from August 2012.

Interview with DOC October 16, 2012 indicated an intervention would be implemented October 16, 2012, to address the identified problem of resident #8.

2. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: For those complaints that can not be investigated and resolved within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution and a follow up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. (3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.)[Ref. Reg 79/10 s. 101 (2)].

A written family member complaint was received by the DOC in August 2012, including multiple questions, comments, and identified resident care complaints of the identified family member and 2 complaints regarding inappropriate provision of nutritional care and complaint of inappropriate staff communication with residents at mealtimes.

A response to the family member was sent from the DOC to acknowledge receipt of the concerns and that the DOC will investigate and get back to the complainant within a week.

Interview of DOC October 16, 2012, indicated a written response to the family member to complaints and questions August 2012, has not been provided to date.

Interview with the DOC October 16, 2012, confirmed that the two complaints regarding inappropriate provision of nutritional care and complaint of inappropriate staff communication with residents at mealtimes. were not investigated.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. **A change of 5 per cent of body weight, or more, over one month.**
2. **A change of 7.5 per cent of body weight, or more, over three months.**
3. **A change of 10 per cent of body weight, or more, over 6 months.**
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure a weight change of 7.5% of body weight or more, over three months, for resident resident #2, was assessed using a multi-disciplinary approach, and that actions are taken and outcomes evaluated.[Ref. Reg. 79/10 s.69].

2.The home's Policy & Procedure #C-55 Resident Weight Monitoring was reviewed and indicated for any weight change of 5% or more from the previous month the Charge Nurse will verify by re-weighing the resident. Re-weights will be completed within 24 hours and entered in Point Click Care. If there is a weight variance of 5% or more an automatic weight change warning will appear in the weight variance section of Point Click Care. The Charge Nurse must indicate reason for the weight change and action taken by clearing the weight change on the dashboard. These notes will automatically appear on the multidisciplinary progress notes.

3.Resident weight records for the identified resident were reviewed and indicated the resident had a weight change (gain) of 4.5 kg.

4.Registered Dietitian interviewed September 10, 2012 @ 11:30 am and confirmed that according to the weight monitoring record, resident #2's weight has gone up by 4kg in the last 2 months. Staff are supposed to re-weigh the resident when there is a discrepancy. There was no re-weigh.

5.RPN interviewed September 10, 2012 @ 10:36 verified a weight change of at least 4kg. for identified time frame, for resident #2. There was no documentation on the resident's health record to indicate communication with the team or referral to the Registered Dietitian.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Critical Incident Report included long-term actions planned to prevent a recurrence of injury to resident #1.[Ref.Reg.79/10 s.104.(1)4.ii].

2.Critical Incident Report alleged an identified staff member squeezed resident #1 causing bruising. Assessment of the identified area showed old bruising and fresh bruising. The investigation was inconclusive for staff abuse of the resident, however, the physician noted the bruise and felt it could have been contributed by two other possible factors.

3.Interview with DOC August 31, 2012, indicated the two possible factors had been considered and corrective action taken.

4.Observation on Aug 31, 2012 @ 10:58, transfer of resident #1 by staff indicated corrective action had not been implemented as reported by the DOC.

5.Resident care plan reviewed and does not include reported corrective actions.

6.Review of resident's health record does not indicate an assessment was conducted based on the Physician's suggested possible factors, to minimize the potential cause of bruising to the resident.

Issued on this 26th day of October, 2012

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