Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 13, 2013	2013_220111_0012	000239, 000128	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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 17, 27 & July 2, 2013

Completed 2 complaint inspections.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Physiotherapist (PT), 2 Registered Practical Nurses (RPN) and 2 Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the health records of two residents, observed two residents and reviewed the homes policy on Medical Directives and Falls Prevention Management.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Related to log #000128:

Review of the progress notes for Resident #2 indicated the resident sustained 3 falls in one month resulting in injury with each fall.

A nursing "Post-Fall Risk Assessment" for Resident #2 was completed after each fall. The assessments indicated reason for assessments were due to recent falls, the resident is a high risk for falls, has had 1-2 falls in last six months, has inadequate vision, has decreased muscle coordination and uses an assistive device.

Review of the "Physiotherapy Quarterly Assessment" following the falls, indicated under:
section A-no history of falls
section c7 (risk of falls)- "not applicable"
section e (goals)- "to educate on safe transfers to prevent falls and to prevent decline in mobility using active exercises and falls prevention program".

The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident related to risk of falls so that their assessments were integrated, consistent with and complemented each other.[s.6(4)(a)]

2. Related to log #000128:

Observation of Resident#2 and interview of staff indicated Resident #2 uses a wheelchair independently for mobility and is independent with all transfers(staff only assist when the resident is in too much pain),is on a 15 minute walking program, frequently refuses all medications, refuses assistance with personal care, will hoard personal belongings in the wheelchair and frequently refuses to allow staff to remove them, and has a history of falls. The resident's room was free of clutter, the call bell and personal items were within reach, a High-Low bed was in the lowest position and 1/2 side rail was in place, a raised toilet seat was in place in the bathroom and commode was at the bedside.

Review of the quarterly RAI-MDS assessment for Resident #2 (following the falls) indicated:

- requires one staff assistance with all transfers, uses a wheelchair for mobility, remains a high risk for falls due to the daily intake of anti-anxiety medications, history of falls in the past quarter (due to always reaching for personal items and refuses assistance), and sustained an injury from one fall requiring transfer to hospital.

Review of Resident #2 Plan of care (post falls)indicated:
1) Transferring- requires one staff assist and resident can weight bear.
2) Risk for falls-related to history of falls (sustaining injury),unsteady gait, and use of psychotropics drugs. Interventions included: environment free of clutter, reinforce need to call for assistance, check every hour for safety, frequent checking when in bedroom, commonly used articles within reach, call bell accessible, encourage to wear proper, non-slip foot wear. There was no indication of hoarding, refusing staff assistance/medications or use of high-low bed and 1/2 side-rails.

The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident related to transferring and risk of falls so that the development and implementation of the plan of care was integrated, consistent with and complemented each other.[s.6(4)(b)]

3. Related to Log #000239:

Review of the progress notes for Resident #1 indicated:
-The resident developed a dry cough and complained of feeling unwell eight days after admission. The resident's symptoms continued for 9 days and was given medication as per the medical directive.No other assessments were documented as completed. The resident was assessed by the Nurse Practitioner (NP)five days later when the Substitute Decision Maker (SDM) insisted the resident be transferred to hospital. The Nurse Practitioner (NP)assessed the resident and noted a significant change in the resident's respiratory status. The resident was transferred to the hospital and diagnosed with pneumonia.

The licensee failed to ensure the resident was reassessed and the plan of care was reviewed and revised when the resident developed a change in the resident's respiratory condition. [s.6.(10)(b)]

LTCHA 2007, s.6 was issued as a Compliance Order on May 22, 2013 as part of

inspection 2013_220111_0006 under LTCHA 2007, s.19 and had a compliance date of June 30, 2013.

Issued on this 15th day of August, 2013

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