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

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

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_0014	000080, 001719, 000504	Critical Incident System

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

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

---

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 24, 25, 27 & July 2, 3, 2013

This inspection was related to 3 critical incidents.
The non-compliance identified in log 001719 under O.Reg. 79/10, s.36 and LTCHA, 2007, s.6(7) has been issued as a Compliance Order under inspection 2013_220111_0013 as part of a follow-up inspection that was completed concurrently.
There is no non-compliance related to log 000504.

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 3 Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed health care records for 2 current residents and 1 deceased resident, observed 2 residents, reviewed the homes investigation records and the homes policy on Fall Prevention Management.

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

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Related to log #000080:

Under O.Reg. 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Review of the homes policy "Falls prevention management" (F-30) stated:
Under section B: Fall and Post-fall Assessment and Management
Registered Nursing Staff:
-notify the attending physician, POA/SDM of the fall, interventions and status of the resident.
-initiate Head Injury Routine (HIR) for all un-witnessed falls.
-monitor vital signs every 30 minutes for one hour and then hourly for 4 hours, then every 4 hours x4, then every shift x 3 shifts.
-complete an incident investigation and incident report.

Review of the progress notes for Resident #2 indicated a PSW reported an injury to the resident's hip. There was no indication HIR was initiated, the physician or SDM were notified or vital signs obtained. Two days later, a second PSW reported the same injury. There was no indication the resident had vital signs monitored every shift x 3 shifts.

Interview of the DOC indicated there was no investigation completed for Resident #2 when staff reported an injury the resident's hip.

Review of the progress notes for Resident #2 indicated a second fall occurred approximately a month later resulting in injury. The resident was placed on HIR for an un-witnessed fall. There was no indication the physician or SDM was notified until the next evening when the resident's condition changed and began to deteriorate. The resident was transferred to hospital and passed away five days later.

The licensee failed to ensure the homes policy of Falls Prevention Management was complied with. [s. 8. (1)]

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 home's policy on Falls Prevention Management is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Related to log # 000080:

A Critical Incident (CI) was received for Resident #2 for a fall resulting in injury and transfer to hospital.

There was no evidence a post-fall assessment completed for Resident #2. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 15th day of August, 2013

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

L Brown