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 12, 2013	2013_195166_0020	002366-12	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

CAROLINE TOMPKINS (166)

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 17,18,19, 20, 21, 24, 2013

This inspection is related to complaint Log O-002366-12.
Non compliance related to inspection 2013_195166_0019(log O-002408-12) have been identified in this report.

During the course of the inspection, the inspector(s) spoke with the resident's Power of Attorney (POA), the Administrator, the Director of Care(DOC) and Registered staff.

During the course of the inspection, the inspector(s) reviewed clinical documentation, staff education related to abuse and neglect, the licensee's program evaluations for 2012, the licensee's investigation into the alleged incident of abuse and the licensee's policies related to the management of Concerns and Complaints and Zero Tolerance of Abuse and Neglect of Residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

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1. The licensee failed to ensure the result of every investigation into alleged, suspected or witnessed abuse of resident is reported to the Director.
Log O-002366-12
A complaint was received from resident #01's POA alleging a PSW deliberately struck resident #01 causing an abrasion.
Interview with the resident's POA and the DOC and review of the licensee's documentation indicated an internal investigation was initiated by the licensee.
There is no documented evidence that the results of the licensee's internal investigation into the incident of alleged staff to resident abuse/neglect was reported to the Director.

Log O-002408-12
The licensee submitted critical incident #C579-000036-12 indicating an incident of alleged staff to resident abuse/neglect had occurred. The critical incident documentation indicated the nurse manager while making rounds in a resident home area, heard a cry from resident #04's room and discovered a resident #04 lying on the floor uncovered and partially dressed. When a personal support worker came to the resident's door, the nurse manager inquired why the resident was on the floor the psw answered the resident #04 was not cooperating.
Interview with the DOC, RPN and PSW and review of the licensee's documentation indicated the licensee initiated an investigation into the allegation of abuse.
There is no documented evidence that the results of the licensee's internal investigation into the incidents of alleged staff to resident abuse/neglect were reported to the Director. [s. 23. (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 the licensee's results of every investigation related to alleged, suspected or witnessed incidents of abuse /neglect is reported to the Director., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report to the Director, the suspicion of abuse/neglect by staff to a resident that resulted in harm or risk of harm.

Log O-002366-12
The MOHLTC received a complaint from resident #01's POA alleging a PSW deliberately struck resident #01 causing a small abrasion.
There is no documented evidence that the suspicion of staff to resident abuse was immediately reported to the Director.

Log O-002408-12
The licensee submitted critical incident #C579-000036-12 which indicated an incident of alleged staff to resident abuse/neglect. The critical incident documentation indicated the nurse manager while on rounds in a resident home area, heard a cry from a resident's room and discovered resident #04 lying on the floor uncovered and partially dressed.
There is no documented evidence that the suspicion of a staff to resident abuse/neglect incident was immediately reported to the Director. [s. 24. (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 anyone who has reasonable grounds to suspect abuse/neglect, improper care or treatment of a resident that resulted in harm or risk of harm to a resident shall immediately report the suspicion and the information upon which it based to the Director., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that a response to a verbal complaint made to licensee and to a staff member, concerning the care of a resident, was given to the complainant indicating what the licensee had done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.
Log O-002366-12
Interview with the Director of Care, resident #01's POA and review of licensee's investigation documentation, indicate there is no evidence the licensee had responded to resident #1's POA related to the resolution of the concern. [s. 101. (1) 3.]

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 a response shall be made to the person who made the complaint, indicating, what the licensee has done to resolve the complaint,or that the licensee believes the complaint to be unfounded and the reasons for that belief., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and the the resident's substitute decision maker, if any, are notified of the results of licensee's investigation immediately on completion of the investigation.
Log O-002366-12
Interview with the resident's Power of Attorney indicated the licensee had advised that a further inquiry into the alleged incident of staff to resident abuse would be initiated.
Resident #01's POA indicated the licensee made no further contact with the resident or resident's POA regarding the incident.
The licensee was not able to produce documented evidence that resident #01 and the resident's POA were notified of the results of the alleged abuse investigation. [s. 97. (2)]

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Issued on this 12th day of August, 2013

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