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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St., 4th Floor
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 18,19, 20 & 21, 2013	2013_195166_0043	Follow up

Licensee/Titulaire
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(s)
Caroline Tompkins #116
Lynda Brown #111

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow-up inspection for logs: 000781, 000961 & 000962. Critical incident inspections were also completed concurrently for logs #000991, 001025 & 001064 as well as one complaint inspection under log #001122.

During the course of the inspection, the inspector(s) spoke with: the Director of Care (DOC), Clinical Educator, Director of Finance, the Physician, Registered Nursing (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family.
During the course of the inspection, the inspector(s): reviewed the clinical health records of 12 residents, policies related to trust accounts and resident charges, falls prevention, staff training records and the home's investigations.
The following Inspection Protocols were used in part or in whole during this inspection:
Critical Incident Response, Prevention of Abuse and Neglect, Falls Prevention, Trust Accounts, Resident Charges, and Responsive Behaviours.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC
2 CO: CO # 0001, 002

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

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NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with s. 36 Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings:
Related to Log # 001122:

A Compliance Order for s.36 was previously issued on October 22, 2012 under inspection 2011_048175_0017 with a compliance date of November 19, 2012. A Compliance Order for s. 36 was issued again on August 13, 2013 during inspection 2013_220111_0013 with a compliance date of August 14, 2013.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Review of the plan of care for Resident #7 indicated the resident required 2 staff for transfers, was a high risk for falls, unable to ambulate and required the use of a lap belt and table top restraint when in a wheelchair.

Review of the progress notes for Resident #7 indicated the resident was found on the floor beside the bed unattended and no restraint in place. Resident #7 sustained injuries as a result and was transferred to hospital for assessment.

Inspector ID #:	166, 111

Additional Required Actions:
CO # - [#001] will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with s. 107.(4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
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 any 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. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident 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 who made the initial report to the Director under subsection (1) or (3), 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. 107 (4).

Findings:
Related to Log # 001122:

A Compliance Order for s.107 (4) was previously issued on October 8, 2013 under inspection 2013_220111_0016 with a compliance date of November 7, 2013.

Review of the progress notes for Resident #7 indicated the resident was found on the floor beside the bed unattended and no restraint in place. Resident #7 sustained injuries as a result and was transferred to hospital for assessment.

Interview of DOC indicated she became aware of the fall incident and initiated an investigation. The DOC indicated the critical incident report was not submitted until date of inspection (40 days later).

Inspector ID #:	166, 111

Additional Required Actions:
CO # - [#002] will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with,
s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).
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; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings:
Related to Log # 001122:

1.The licensee failed to ensure the care set out in the plan of care related to transferring and restraints is provided to the resident as specified in the plan [s.6(7)]

Review of the progress notes for Resident #7 indicated the resident was found on the floor beside the bed unattended and no restraint in place. Resident #7 sustained injuries as a result and was transferred to hospital for assessment.
Review of the plan of care for Resident #7 indicated the resident required 2 staff for transfers, was a high risk for falls, unable to ambulate and required the use of a lap belt and table top restraint when in a wheelchair.

2. The licensee failed to ensure that when the resident was reassessed, the plan of care was reviewed and revised when the resident's care needs changed related responsive behaviours [s.6 (10) (b)].

Related to Log# 001064:

Critical incident report indicated Resident #9 became verbally and physically aggressive towards staff and residents. Resident #9 was using a mobility device attempting to hit other resident's and staff. Resident #10 attempted to talk to Resident #9 when Resident #9 became physically aggressive towards Resident #10. Resident #10 did not sustain any injuries. Resident #9 was transferred to the hospital for further assessment.

Review of the plan for care for Resident #9 indicated the resident demonstrated responsive behaviours of agitation, physical aggression and resistive behaviours towards staff and other residents.
There was no indication in the plan of care related to the resident's use of a mobility device as a potential instrument of harm or the use of medications as an intervention in managing the resident's responsive behaviours of agitation and aggression[s.6(10)(b)].

3. The licensee failed to ensure that when the resident returned from hospital, the plan of care was reviewed and revised when the resident's care needs changed related responsive behaviours [s.6 (10) (b)].
Related to Log #000961:
Review of progress notes for Resident #4 indicated the resident demonstrated responsive behaviours of wandering/exit seeking, agitation (screaming, crying, throwing food), and resistive to care. The interventions utilized included frequently administering anti-anxiety medication.

Review of the plan of care for Resident #4 indicated the resident demonstrated responsive behaviours of verbal/physical aggression and resistive to care.
There was no indication of the resident's wandering/exit seeking behaviours or the frequent use of anti-anxiety medication as an intervention.
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 care set out in the plan of care is provided to the resident as specified in the plan related to transferring and positioning and that the residents with responsive behaviours are 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;(b) the resident's care needs change or the care set in the plan is no longer necessary;(c)care set out in the plan has not been effective, to be implemented voluntarily.

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Inspector ID #:	166, 111

CORRECTED NON-COMPLIANCE
Non-respects à Corrigé

REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
1) LTCHA, 2007, c. 8, s.19(1) [includes LTCHA, 2007, s.6(1)(c) & O.Reg. 79/10, s.53(4)] 2) O. Reg. 79/10, s.24(1) 3) O. Reg. 79/10, s. 98	CO CO CO	001 002 004	2013_220111_0016	#166 & #111
1)O.Reg. 79/10, s. 241(8) 2) O.Reg. 79/10, s.91(4)	CO CO	001 002	2013_220111_0015	#166 & #111
O.Reg. 79/10, s. 221(1)1	CO	001	2013_220111_0013	#166 & #111

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. [signature] #166
Title: Date:	Date of Report: (if different from date(s) of inspection). November 27. 2013

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Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Caroline Tompkins & Lynda Brown	**Inspector ID #**	166 & 111
Log #:	000961 & 000781		
Inspection Report #:	2013_195166_0043		
Type of Inspection:	Follow-up		
Date of Inspection:	November 18, 19, 20 & 21, 2013		
Licensee:	The Wexford Residence Inc. 1860 Lawrence Avenue East, Toronto, ON, M1R-5B1		
LTC Home:	The Wexford 1860 Lawrence Avenue East, Scarborough, ON M1R-5B		
Name of Administrator:	Sandy Bassett		

To The Wexford Residence Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
The Licensee has failed to comply with s. 36 Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order:
The licensee shall ensure that staff who provide direct care to residents use safe transferring and positioning devices or techniques when assisting residents.

Grounds:
Related to log # 001122:

A Compliance Order for s.36 was previously issued on October 22, 2012 under inspection 2011_048175_0017 with a compliance date of November 19, 2012. A Compliance Order for s. 36 was issued again on August 13, 2013 during inspection 2013_220111_0013 with a compliance date of August 14, 2013.

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Direction de l'amélioration de la performance et de la conformité

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Review of the plan of care for Resident #7 indicated the resident required 2 staff for transfers, was a high risk for falls, unable to ambulate and required the use of a lap belt and table top restraint when in a wheelchair.

Review of the progress notes for Resident #7 indicated the resident was found on the floor beside the bed unattended and no restraint in place. Resident #7 sustained injuries as a result and was transferred to hospital for assessment.

This order must be complied with by:	November 27, 2013

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to:
The Licensee has failed to comply with s. 107.(4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
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 any 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. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident 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 who made the initial report to the Director under subsection (1) or (3), 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. 107 (4).

Order:
The licensee shall prepare, submit and implement a plan of correction that includes:
-the person(s) responsible for completing and submitting the critical incident reports within the

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Performance Improvement and Compliance Branch

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legislative time requirements.
-to ensure the reports include type of incident, a description of the incident that includes area/location of the incident, date and time of the incident and events leading up to the incident, and description of the individuals involved in the incident (staff and residents), and actions taken as a result of the incident (both immediate and long term).

This plan is to be submitted to Caroline Tompkins via email at caroline.tompkins@ontario.ca by Dec.3, 2013.

Grounds:
Related to Log # 001122:

A Compliance Order for s.107 (4) was previously issued on October 8, 2013 under inspection 2013_220111_0016 with a compliance date of November 7, 2013.

Review of the progress notes for Resident #7 indicated the resident was found on the floor beside the bed unattended and no restraint in place. Resident #7 sustained injuries as a result and was transferred to hospital for assessment.

Interview of DOC indicated she became aware of the fall incident and initiated an investigation. The DOC indicated the critical incident report was not submitted until date of inspection (40 days later).

This order must be complied with by:	December 3, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28

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days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 26 day of November, 2013	
Signature of Inspector:	[signature] [signature]
Name of Inspector:	C. Tompkins L. Brown
Service Area Office:	Ottawa Service Area Office (OSAO)