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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2018	2017_678680_0025	009986-16, 027736-16, 029690-16	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street MARKDALE ON N0C 1H0

Long-Term Care Home/Foyer de soins de longue durée

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH MARKDALE ON N0C 1H0

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

TRACY RICHARDSON (680)

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): December 21 and 22, 2017, January 1 and 2, 2018.

The following complaints were inspected:
Log #009986-16, IL-13272 -LO, regarding alleged improper lifts and transfers
Log #029690-16, regarding concerns in nutrition and hydration, lifts and transfers, medication administration, bathing, care planning and insufficient staffing concerns.

The following Critical Incident was inspected during this inspection:
Log #009986-16, Critical Incident #M606-000004-16, regarding alleged improper/incompetent treatment of a resident that results in harm or risk of harm to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Labour Relations Officer, the Dietitian, Registered Practical Nurses, Registered Nurses, Personal Support Workers, and a family member.

The inspector(s) also made observations of residents, activities and care of residents. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 9. Every resident has the right to have his or her participation in decision-making respected.

A Critical Incident System (CIS) report was submitted to Ministry of Health and Long-Term Care (MOHLTC), related to an improper transfer which resulted in an injury to a specified resident.

The CIS stated that a Personal Support Worker (PSW) completed a specific transfer for the specified transfer and the resident required a different transfer method. The CIS stated that the resident had asked the PSW for a specific transfer method to be used. The CIS also stated that the staff did not use the requested transfer technique and resulted in an injury.

A skin/wound care assessment was completed on a specified date stated the resident had sustained an injury.

Review of the progress note showed that the specified resident was cognitively able to make decisions.

Review of a specific letter to the PSW involved in the transfer dated on a specific date showed that the resident was transferred using a transfer method they did not wish to use and an injury resulted.

Review of the resident plan of care showed a focus for transfer method that did not match the method that was used. The care plan also showed resident was able to make their own decisions.

Review of the Physiotherapy Assessment showed which transfer method the resident was to use after the assessment.

Review of the notes provided by the Administrator indicated the resident did not wish for that type of transfer method to be used and that the resident had been injured in the transfer.

In an interview a PSW shared that they had been present during the transfer of the

specified resident when the injury occurred. The PSW shared that the resident was transferred using a type of transfer method that the resident did not wish to use. The PSW acknowledged that the injury occurred during this transfer.

The Labour Relations Officer (LRO) stated that the one staff member was terminated because the staff member transferred the specified resident using a transfer that the resident did not want to do, and resulted in an injury.

The Administrator acknowledged that the resident was transferred by a method that was not what the resident wanted used and that an injury had occurred. The Administrator acknowledged that the staff member had been terminated related to this incident.

The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 9. Every resident has the right to have his or her participation in decision-making respected. [s. 3. (1) 9.]

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: 9. Every resident has the right to have his or her participation in decision-making respected, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, 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/Faits saillants :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the specified resident.

A Critical Incident System (CIS) report was submitted to Ministry of Health and Long-Term Care (MOHLTC), related to an improper transfer which resulted in an injury to a

specified resident.

The CIS stated that a Personal Support Worker (PSW) completed a specific transfer method other than the transfer requested by the resident. The CIS stated that the resident had asked the PSW for a type of transfer that was listed in the residents plan of care. The CIS also stated that the staff completed the transfer which resulted in injury to the resident.

A skin/wound care assessment was completed which stated that the resident sustained an injury.

Review of the progress note showed that the specified resident was cognitively able to make decisions.

Review of the resident plan of care showed a focus for transfer method that did not match the method that was used. The care plan also showed the resident was able to make their own decisions.

Review of the Physiotherapy Assessment showed which transfer method the resident was to use after the assessment.

Review of the policy titled "Resident Transfer and Lift Procedures," dated last revision date December 2015, stated the following:
"1. Lift/transfer resident according to plan of care/logo card.
3. Communicate to registered staff any changes in resident condition/behaviour that may impact the lift/transfer being performed.
4. Use a higher level of assistance (lift/transfer) if unsure about resident's capabilities, e.g. using a mechanical lift in the afternoon shift if resident appears too fatigued to perform a 2-person assisted transfer."

Review of the notes provided by the Administrator indicated the resident did not wish for that type of transfer method to be used and that the resident had been injured in the transfer.

In an interview a PSW shared that they had been present during the transfer of the resident when the injury occurred. The PSW shared that they had been present during the transfer of the specified resident when the injury occurred. The PSW shared that the resident was transferred using a type of transfer method that the resident did not wish to

use. The PSW acknowledged that the injury occurred during this transfer.

In an interview a PSW stated that they would not complete a lift that did not match the transfer logo of the resident.

The Labour Relations Officer (LRO) #105 stated that there was no logo in the room for staff to follow.

The Administrator acknowledged that the resident was transferred by a method that was not what the resident wanted used and that an injury had occurred. The Administrator acknowledged that the staff member had been terminated related to this incident.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the specified resident. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 30th day of January, 2018

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

Original report signed by the inspector.