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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 3, 2018	2017_324535_0022	018146-17	Complaint

Licensee/Titulaire de permis

INA GRAFTON GAGE HOME OF TORONTO
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

INA GRAFTON GAGE HOME
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

VERON ASH (535)

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): November 28, 29, 30, December 1, 2017.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DON), Nurse Manager (NM), Associate Nurse Manager (ANM), Registered Dietitian (RD), Physiotherapist (PT), registered staff (RN/ RPN), personal support worker (PSW), Substitute Decision Makers (SDMs).

During the course of the inspection, the inspector conducted observations of staff to resident interactions and feeding of meals, provision of care, conducted interviews, reviewed health records, staff training records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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

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

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. 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The Ministry of Health (MOH) received a complaint related to resident #001 who was not receiving assistance required during meals.

Record review of the home's Minimum Data Set (MDS) assessment revealed that resident #001 was total dependent on staff for feeding meals; and the resident was ordered a regular diet. The resident health records also revealed that he/she received an assessment regularly because of a related diagnosis. During an interview, registered staff #106 confirmed the diagnosis; and stated that the resident was provided medication to support the diagnosis, and that the medication had been effective.
The inspector observed the resident during various meals and noted the following:

On an identified date, the inspector observed a PSW slowly and patiently feed the resident; and the resident appeared to tolerate the meal and enjoyed the interaction with the PSW during the meal.

On a second identified date, the inspector observed the resident was fed by a PSW; and the resident appeared to tolerate the meal and enjoyed the interaction with the PSW during the meal.

On a third identified date, the inspector observed the resident refused to eat and was left with the meal to feed him/herself for a while; then the PSW and registered staff took turns re-approaching and encouraging the resident to eat by assisting with feeding the meal.

On a fourth identified date, the inspector observed the resident ate all of the meal with few exceptions. During an interview, the inspector asked PSW #108 what strategies does he/she use to encourage the resident to eat the meal; and the PSW stated that in order to encourage the resident to eat as much as possible, he/she would engage the resident in conversation related to a topic of interest to the resident. The PSW stated that the resident loved talking about this specific topic and would attempt to respond with incomprehensible language; however he/she would also eat the meal. The PSW stated that this strategy was time consuming, but the resident would generally eat with encouragement while engaged in conversation.

On a fifth identified date, the inspector observed PSW #102 engage the resident in conversation related to the specific topic; and the resident ate all the meal. During an interview, PSW #102 stated that the strategy of conversing with the resident while feeding the meal appeared to be successful a high percentage of time, but not always. PSW #102 confirmed that this information did not appear in the resident plan of care; and that he/she had not informed the registered staff about this information directly.

During an interview, registered staff #106 stated that he/she was not aware that the resident enjoyed engaging in conversation related to the topic of interest; however he/she confirmed that engaging the resident in conversation related to the topic of interest was not included in the resident plan of care; and that it should be included in the plan of care in order to promote consistency while feeding the resident. The information was added to the plan of care after the interview was completed.

2. The licensee has failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

The Ministry of Health (MOH) received a complaint related to a resident who experienced a fall and was transferred to hospital with an injury causing significant change in health

status.

Record review revealed, and during an interview Nurse Manager and falls prevention lead #103 confirmed the following information: on an identified date, resident #001 experienced an unwitnessed fall and was found lying on the floor. As a result of the fall, the resident sustained an injury and was transferred to acute care hospital for a procedure. The resident returned to the home; and the same falls intervention strategies remained in place. On a second identified date, resident #001 experienced another unwitnessed fall onto the floor with no injury sustained. Record review revealed that fall prevention strategies remained in place and unchanged from before. On a third identified date, resident #001 experienced another unwitnessed fall in his/her room and sustained an injury. The resident was assessed and seen in the home by the Nurse Practitioner who provided treatment. After this final incident, the home reviewed and revised the fall prevention strategies in place and implemented additional strategies to ensure the resident's safety and prevented future falls. A restraint was implemented with the consent of the physician and the family; and special monitoring device used to ensure the resident safety going forward.

During an interview, the Nurse Manager and fall prevention lead confirmed that the resident should have been reassessed after the first and second falls because it was apparent that the falls strategies in the plan of care were not effective, and different strategies should have been considered after each fall. The Nurse Manager further stated that after the last fall incident, the home implement a strategy to keep the resident safe and since then there has been no other fall occurrence related to this resident.

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 and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; and
-to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that personal items, including personal aids such as dentures, glasses and hearing aids, were labelled within 48 hours of admission and of acquiring in the case of new items.

On multiple identified dates, the inspector observed resident #001 wore glasses to correct his/her vision; however the inspector observed that both pairs of glasses were not labelled. During interviews, PSW #102 and registered staff RN #106 both confirmed the resident's glasses were not labelled; and that both pairs of glasses should have been labelled.

During an interview, DON #101 stated that each resident of the home should have his/her personal items labelled on admission and when new items were brought in by the family; therefore, resident #001's two pairs of glasses should have been labelled.

Issued on this 8th day of January, 2018

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

Original report signed by the inspector.