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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 23, 2018	2018_714673_0008	012410-18	Resident Quality Inspection

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

BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589), REBECCA LEUNG (726)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 20-22 and 25-29, 2018

During this inspection, the inspectors conducted observations of resident to resident interactions, staff to resident interactions and the provision of care. The inspectors also conducted record reviews of residents' health records, the home's policies/procedures and medication incidents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietician (RD), Personal Support Workers (PSW), Physiotherapist (PT), Dietary Aides (DA), Director of Support Services (DSS), Residents, and Family Members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **1 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	Légende 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 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 :

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

During an observation on a specified date, the inspector followed Personal Support Worker (PSW) #116 into resident #003's room and observed a mechanical lift in the room, and resident #003 being adjusted into their specified assistive device by PSW #123.

In an interview, resident #003 stated that only one of the staff had helped them with the transfer by using a mechanical lift and that usually only one staff member helps them with their transfers using the lift.

A review of the home's policy titled Resident Safety: Transfers, with Index I.D E-20, revised May 4, 2018, stated the following:
- residents requiring the use of a mechanical lift and/or ceiling lift will be assisted by two staff at all times to promote both resident and staff safety
- the level of intervention for transferring with a mechanical lift is noted on the plan of care and kardex.

A review of resident #003's most recent annual Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment, and written plan of care, stated that they required extensive assistance by two staff for transfers with a mechanical lift. The plan of care further stated that if resident #003 displayed responsive behaviours, to report the issue to registered staff, and to gently redirect or re-approach resident #003 at a later time.

In an interview, Registered Practical Nurse (RPN) #119 stated that resident #003 requires a mechanical lift and extensive assistance from two staff for transfers.

In an interview, PSW #116 stated that they did not assist PSW #123 with the transfer of resident #003 on the identified date of the inspector's observation.

In an interview, PSW #123 stated that they had transferred resident #003 with the mechanical lift on their own as they feared that resident #003 would exhibit behaviors. PSW #123 further stated that the resident did not exhibit such behaviors on this identified date, and acknowledged that if they had, registered staff could have been informed, or the resident could have been re-approached at a later time. PSW #123 stated that they had not followed the home's policy related to the requirement for two staff members for transfers involving a mechanical lift, and that this had put resident #003 at a risk for falls/harm.

In an interview, Director of Care (DOC) #101 acknowledged that by independently transferring resident #003 using a mechanical lift on the identified date of the inspector's observation, PSW #124 had used unsafe transferring techniques. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, was fully respected and promoted.

A review of resident #008's most recent RAI-MDS assessment, and plan of care indicated their assessed bowel and bladder functions, the identified incontinence products they used, and that they required assistance with toileting. Interventions included a specified toileting schedule for resident #008 with the goal of them receiving the necessary assistance to be clean, dry and odor free.

During an interview, resident #008 told the inspector that staff #118 usually toilets them at specified times, but between those specified times, staff did not check whether they required incontinence care or toileting as they stated that they were too busy to help so they remained wet and uncomfortable in their incontinence product. Resident #008 also told the inspector that their incontinence product needed to be changed, so the inspector encouraged them to use their call bell to request assistance. After PSW #116 was observed attending to resident #008's call bell and then leaving shortly afterwards,

resident #008 told the inspector that PSW #116 had said that they were 'not wet enough'.

In an interview, PSW #116 stated that resident #008 had not been toileted as per their toileting schedule as specified in their plan of care as they were sleepy. PSW #116 further stated that when they responded to the resident's call bell, they had checked resident #008's incontinence product without opening it up, and observed that it was 'not that wet´ and the lines on the outside of the brief, that indicate it is wet, were not visible. PSW #116 confirmed telling resident #008 that they were 'not wet enough´ and stated that they instructed the resident to call again if they needed to be changed.

The inspector requested to see the lines on the brief that PSW #116 was referring to; however, during observation, resident #008 was noted to be wearing a different type of incontinent product, as confirmed by PSW #116, which had no lines on the outside of it. PSW #116 then stated they were referring to the lines that would show after the urine had soaked through the back side of the brief. At this time, in the presence of the inspector, resident #008 once again expressed that they wanted to be changed, so PSW #116 assisted the resident with changing their incontinent product. Resident #008's used incontinent product, was observed, and was validated by PSW #116 to be moderately soaked.

In interviews, PSW #117 and RPN #119 stated that if a resident requests to have their incontinent product changed, it should be changed immediately. PSW #117 further stated that if staff want to check the incontinent product, they should do so by opening it up as not all products have the lines to indicate it is wet, and because the lines do not indicate whether the resident has had a bowel movement.

In an interview, DOC #101 stated that if a resident communicates that they are wet and uncomfortable, the staff should change their incontinent product. DOC #101 acknowledged that PSW #116 had not respected resident #008's right to be properly clothed and cared for, as they had not changed resident #008's incontinent product when they expressed that they were wet and uncomfortable and requested for it to be changed. [s. 3. (1) 4.]

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 resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: 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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

A review of resident #004's weights/vitals in the home's electronic documentation system indicated they had experienced an identified change in weight within an identified period.

A review of the most recent plan of care and the current diet sheet indicated to serve resident #004's courses in a specified way during meals, to ensure that they complete their meals.

On an identified date, an observation conducted by the inspector during a specified meal service revealed resident #004 was not served their courses in the specified way

identified in their plan of care and current diet sheet. Five to ten minutes later, resident #004 got up from their seat and left the dining room area without being served all of the food courses.

In interviews, PSW #111 and DA #120 stated that the intervention related to serving courses in a specified way, as identified in resident #004's plan of care, should be followed to prevent them from leaving the dining room and to ensure that they complete their meal. DA #120 further stated they rely on the PSW staff to inform them of when resident #004 is seated in the dining room so that they can ensure that the intervention related to serving courses in a specified way could be implemented.

In an interview, DOC #101 verified that staff had failed to ensure the care set out in the plan of care had been provided to resident #004 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change.

A review of the home's policy titled Resident Safety: Transfers, with Index I.D E-20, revised May 4, 2018, stated the following:
- all residents will be assessed for the use of an appropriate type of lift and sling,
- residents will be assessed/reassessed for their ability to transfer by Registered Staff and Physiotherapist if there has been a significant change,
- the level of intervention for transferring with a mechanical lift is noted on the plan of care and kardex.

During an interview, Physiotherapist (PT) #124 communicated the same points as mentioned above when asked about the home's process for transferring residents with mechanical lifts.

A record review of resident #005's progress notes showed that the most recent Lift, Transfer and Bed Safety Assessment was completed on a specified date, by DOC #101, and indicated that resident #005 required independent supervised transfer. A review of resident #005's written plan of care with an identified date approximately three months later stated that resident #005 required limited physical assistance from one person for transfers related to identified health conditions. It further stated that resident #005 was at a specified risk level for falls, and had a history of multiple falls due to an identified health condition.

Resident #005's progress notes indicated that they sustained a specified number of falls within an identified time period, including a transfer to hospital on a specified date as a result of a fall resulting in an alteration in skin integrity to a specified location on their body, which required a specified skin intervention.

In an interview, RN #127 stated that there had been a significant change in resident #005's condition since their most recent fall and transfer to hospital, as there had been a change in specified symptoms, functioning and occurrences of falls. RN #127 further stated that in relation to transfers and safety, the expectation is for registered staff to complete a Lift, Transfer and Bed Safety Assessment if there is a change in a resident's condition.
In interviews, PSW #125 stated that they were currently using a mechanical lift to transfer resident #005. PSW #126 stated that they had been using a mechanical lift since the resident's most recent fall and hospital visit, and a different mechanical lift before that.

The inspector brought the issue of a mechanical lift being used for resident #005, contrary to their assessments and plan of care, to the attention of DOC #101 and PT #124.

The following day, a record review indicated that a Lift, Transfer and Bed Safety Assessment was initiated, and the plan of care was updated for resident #005 by PT #124. The revised plan of care stated that resident #005 required physical assistance by two people, without a mechanical lift, for transferring resident #005.

In an interview, PT #124 stated that the nurses are responsible for sending them a referral for a Lift, Transfer and Bed Safety Assessment to be completed, and that although they had completed post falls assessments, they had not received a referral for a Lift, Transfer and Bed Safety Assessment to be completed for resident #005. Physiotherapist #124 acknowledged that a Lift, Transfer and Bed Safety Assessment had not been completed for resident #005 since the identified date that the last Lift, Transfer and Bed Safety Assessment had been completed, or after the identified date that resident #005 had a significant change in condition.

In an interview, DOC #101 acknowledged that resident #005 was not re-assessed in relation to lifts and transfers, and their plan of care was not reviewed and revised when resident #005's condition/care needs changed. [s. 6. (10) (b)]

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, and that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that with respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, any equipment, supplies, devices, assistive aids, or positioning aids used by the staff are appropriate for the resident and based on the resident's condition.

A review of the home's policy titled Resident Safety: Transfers, with Index I.D E-20, revised May 4, 2018, stated the following:
- all residents will be assessed for use of appropriate type of lift and sling,
- residents will be assessed/reassessed for ability to transfer by Registered Staff and Physiotherapist if there has been a significant change,
- a mechanical lift will be used when deemed appropriate to provide lifts/transfer that are safe for both residents and staff, and
- the level of intervention for transferring with a mechanical lift will be noted in the plan of care and kardex.

During an interview, PT #124 communicated the same points as mentioned above when asked about the home's process for transferring residents with mechanical lifts.

A record review of resident #005's progress notes showed that the most recent Lift, Transfer and Bed Safety Assessment was completed on a specified date, by DOC #101, and indicated that resident #005 required independent supervised transfer. A review of resident #005's written plan of care with an identified date approximately three months later stated that resident #005 required limited physical assistance from one person for transfers related to identified health conditions. It further stated that resident #005 was at a specified risk level for falls, and had a history of multiple falls due to an identified health condition.

Resident #005's progress notes indicated that they sustained a specified number of falls within an identified time period, including a transfer to hospital on a specified date as a result of a fall resulting in an alteration in skin integrity to a specified location on their body, which required a specified skin intervention.

In an interview, RN #127 stated that there had been a significant change in resident #005's condition since their most recent fall and transfer to hospital, as there had been a change in specified symptoms, functioning and occurrences of falls. RN #127 further stated that in relation to transfers and safety, the expectation is for registered staff to complete a Lift, Transfer and Bed Safety Assessment if there is a change in a resident's

condition.

In interviews, PSW #125 stated that they were currently using a mechanical lift to transfer resident #005. PSW #126 stated that they had been using a mechanical lift since the resident's most recent fall and hospital visit, and a different mechanical lift before that. The inspector brought the issue of a mechanical lift being used for resident #005, contrary to their assessments and plan of care, to the attention of DOC #101 and PT #124.

The following day, a record review indicated that a Lift, Transfer and Bed Safety Assessment was initiated, and the plan of care was updated for resident #005 by PT #124. The revised plan of care stated that resident #005 required physical assistance by two people, without a mechanical lift for transfers.

In an interview, DOC #101 stated that a lift is determined to be appropriate to use for a resident based on a Lift, Transfer and Bed Safety Assessment completed by registered staff, and that a reassessment should be completed if there is a change in a resident's condition. DOC #101 acknowledged that using a mechanical lift to transfer resident #005 was not appropriate based on the resident's condition as their assessments did not indicate the use of any mechanical lifts. [s. 30. (1) 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 with respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, any equipment, supplies, devices, assistive aids, or positioning aids used by the staff are appropriate for the resident and based on the resident's condition., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), and attending physician.

During the completion of the mandatory medication inspection protocol as part of the RQI, the inspector reviewed three medication incidents.

A review of the home's policy titled Medication Incident, Index ID F-45, dated May 4, 2018, stated that a medication incident constitutes any involvement in the dispensing or administration of the following: wrong drug, dosage, route/method, wrong time, omission, wrong resident, missed sign offs, adverse reaction. It further stated that in the case of a medication incident, an assessment of the resident should be completed, the resident's SDM and physician should be notified, and the incident and actions should be documented in the resident's progress notes.

A) A review of an identified medication incident report with a specified date, stated that an order was written for resident #020 on an identified date, to discontinue an identified mediation after one month; however, the pharmacy continued to dispense this medication. The medication incident report did not indicate whether the resident was assessed, if the resident's SDM was informed after the discovery of this medication incident, or whether this dispensed medication was administered to resident #020 from the time it was ordered to be discontinued to the time the error was discovered.

A review of a progress note by the physician from the same date as the identified medication was discontinued for resident #020, indicated that this identified medication may have resulted in changes in the resident's level of food intake. A review of resident #020's medication orders indicated that on this same identified date, the physician had ordered for this identified medication to be decreased to a specified dose, and then to be discontinued after a specified period of time. The progress notes did not indicate whether the SDM was informed, or if an assessment of resident #020 had been completed related to the medication incident.

In an interview, RPN #119 stated they completed an assessment of resident #020, but did not document it, nor did they inform the SDM as they thought that Nurse Manager (NM) #122 would have done so. In an interview, NM #122 stated that they thought that RPN #119 would have informed resident #020's SDM about the medication incident.

In an interview, DOC #101 acknowledged that documentation had not been completed to confirm that the resident was assessed, and that the resident's SDM was not informed following this medication incident involving resident #020.

B) A review of an identified medication incident report number with a specified date, stated that a packaging/dispensing error by the pharmacy had resulted in resident #019's blister pack of identified medications missing an identified dose. The medication incident report did not indicate whether the SDM and physician were informed of the incident.

A review of resident #019's progress notes also did not indicate that resident #019's SDM and doctor were informed about this medication incident.

In interviews, NM #122 and DOC #101 stated that upon discovery of a medication incident, the expectation is that registered staff complete an assessment of the resident, inform the SDM and physician, and then document these actions in the incident report or progress notes.

DOC #101 acknowledged that documentation had not been completed to confirm that the physician had been informed, and that the SDM was not informed about this medication incident involving resident #019. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, corrective action was taken as necessary, and a written record was kept of this.

A) A review of a medication incident report with a specified date, stated that an order was written for resident #020 on an identified date, to discontinue an identified medication after a specified period of time; however, the pharmacy continued to dispense the medication. The report identified that the precipitating event/contributing factors leading to this medication incident included staff education and a lack of quality control/ independent check systems. The medication incident report did not indicate the corrective action taken in relation to these issues. It also did not indicate whether this dispensed medication was administered to resident #020 from the time it was ordered to be discontinued to the time the error was discovered.

A review of a progress note by the physician from the same date as the identified medication was discontinued for resident #020, indicated that this identified medication may have resulted in changes in the resident's level of food intake. A review of resident #020's medication orders indicated that on this same identified date, the physician had ordered for this identified medication to be decreased to a specified dose, and then to be discontinued after a specified period of time.

A review of resident #020's electronic medication administration records (EMAR) stated that the identified medication was in fact discontinued on the same date it was ordered to have been discontinued by the physician and the lowered dose of the identified medication was started the next day, and last administered to the resident one month later. This medication was not listed on the EMAR for the following month after the identified date of the last administration.

In an interview, RPN #119 stated that they had discovered the dispensing error on an identified date during the month following the date of the last administration of the identified medication. RPN #119 stated that they took a picture of the pouch and informed NM #122. Observation of the picture taken by RPN #119 showed that the identified medication was packaged by the pharmacy in the same medication pouch as

two of resident #020's other medications. RPN #119 stated that they had worked 20 shifts between the time that the identified medication was ordered to be discontinued and the day that the error was discovered, but could not remember if they had administered this medication to resident #020 during this period.

In an interview, DOC #101 stated that corrective action for medication incidents where registered staff have administered a medication to a resident when it should have been discontinued as per the physician's orders, would be to provide education, coaching, and auditing of all staff involved. DOC #101 further stated that the home had not investigated whether other staff had incorrectly administered the identified medication to resident #020 between the time it was ordered to be discontinued to the time the error was discovered. Although NM #122 had talked to RPN #119 about the incident and advised them to complete appropriate medication checks, this corrective action was not documented. DOC #101 acknowledged that necessary corrective action was not taken and documented in relation to this medication incident involving resident #020. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; reported to the resident, the resident's substitute decision maker (SDM), and attending physician; and that corrective action is taken as necessary and a written record is kept of this, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

A review of resident #008's RAI-MDS assessment completed on a specified date, indicated that they used incontinent products.

In an interview RPN #119 stated that the plan of care for the type of incontinence product to be used for each resident is based on their assessment, and noted on a list located on each of the care carts used by the PSWs, which staff are to refer to when providing continence care. An observation of this list on one of the carts with RPN #119, indicated that resident #008 was to use an identified incontinent product.

In an interview, PSW #117 stated that resident #008 wears the identified incontinent products identified in their plan of care.

During an observation, on an identified date, resident #008 was noted to be wearing a different type of incontinent product, and was changed into this same incontinent product by PSW #116 during care. The incontinent product that resident #008 was wearing, and was changed into, was not the correct incontinent product identified in their plan of care.

In an interview, resident #008 told the inspector that their staff #118 provides continence care to them each morning and afternoon.

In an interview, Staff #118 stated that they had been using a different type of incontinent product than the one identified in the plan of care for resident #008, but had been recently instructed by staff to use the ones identified in the plan of care.

In an interview, DOC #101 acknowledged that PSW #117 and Staff #118 did not implement resident #008's plan of care as per their plan in relation to the type of incontinence product they had been assessed to use. [s. 51. (2) (b)]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 27th day of February, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589), REBECCA LEUNG (726)
Inspection No. / No de l'inspection :	2018_714673_0008
Log No. / No de registre :	012410-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 23, 2018
Licensee / Titulaire de permis :	Ina Grafton Gage Home of Toronto 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
LTC Home / Foyer de SLD :	Ina Grafton Gage Home 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Althea Bess

To Ina Grafton Gage Home of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with r. 36 of the LTCHA.

Specifically, the licensee must:
- ensure that staff use safe transferring and positioning devices or techniques when assisting residents
- provide and document education/training for all direct care staff related to safe transferring and positioning devices/techniques
- ensure staff are aware of, and following residents' assessed transfer needs/interventions as per their plan of care and the home's policies
- complete and document random audits of resident transfers on all units ten times over the next three months to ensure staff are using safe transferring and positioning devices or techniques when assisting residents.

Grounds / Motifs :

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

During an observation on a specified date, the inspector followed Personal Support Worker (PSW) #116 into resident #003's room and observed a mechanical lift in the room, and resident #003 being adjusted into their specified assistive device by PSW #123.

In an interview, resident #003 stated that only one of the staff had helped them with the transfer by using a mechanical lift and that usually only one staff helps them with their transfers using the lift.

A review of the home's policy titled Resident Safety: Transfers, with Index I.D

E-20, revised May 4, 2018, stated the following:
- residents requiring the use of a mechanical lift and/or ceiling lift will be assisted by two staff at all times to promote both resident and staff safety
- the level of intervention for transferring with a mechanical lift is noted on the plan of care and kardex.

A review of resident #003's most recent annual Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment, and written plan of care dated, stated that they require extensive assistance by two staff for transfers with a mechanical lift. The plan of care further stated that if resident #003 displayed responsive behaviours, to report the issue to registered staff, and to gently redirect or re-approach resident #003 at a later time.

In an interview, Registered Practical Nurse (RPN) #119 stated that resident #003 requires a mechanical lift and extensive assistance from two staff for transfers.

In an interview, PSW #116 stated that they did not assist PSW #123 with the transfer of resident #003 on the identified date of the inspector's observation. In an interview, PSW #123 stated that they had transferred resident #003 with the mechanical lift on their own as they feared that resident #003 would exhibit behaviors. PSW #123 acknowledged that the resident did not exhibit such behaviors on approach, but if they had, the registered staff could have been informed, or the resident could have been re-approached at a later time. PSW #123 further acknowledged that they had not followed the home's policy related to two staff members being required for transfers involving a mechanical lift, and that this had put resident #003 at a risk for falls/harm.

In an interview, Director of Care (DOC) #101 acknowledged that by independently transferring resident #003 using a mechanical lift on the identified date of the inspector's observation, PSW #124 had used unsafe transferring techniques.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the resident. The scope of the issue was a level one as it related to one out of three residents reviewed. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:

- Voluntary Plan of Correction (VPC) issued August 25, 2015 (2015_405189_0014);
- VPC issued September 15, 2015 (2015_405189_0017);
- VPC issued June 24, 2016 (2016_377502_0010);
- VPC issued May 23, 2017 (2017_644507_0006);
- VPC issued November 27, 2017 (2017_324535_0021).

Due to the severity, scope, and history, a compliance order is warranted. (673)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2018

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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Babitha Shanmuganandapala

Service Area Office /
Bureau régional de services : Toronto Service Area Office