Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2014	2014_237500_0021	T-183-14/T-808-13	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

NITAL SHETH (500)

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): October 15, 16, 17, 2014.

During the course of the inspection, the inspector(s) spoke with the Resident Assessment Instrument (RAI) coordinator, registered nursing staff, personal support workers (PSWs), and family member.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 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. 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #29's plan of care revealed that the resident is wandering and going into other resident rooms related to cognitive impairment. His/her current plan of care indicated staff to document resident's location hourly on wanderer's checklist.

Interview with the PSW and registered nursing staff confirmed that they are not aware about hourly documentation of wanderer's check list.

Interview with the RAI Coordinator confirmed that the home did not implement an hourly wanderer's checklist for the resident. [s. 6. (7)]

2. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

Interview with the PSW confirmed that he/she was not aware of the strategies to be used

to address resident #29's wandering behaviour.

Interview with the RAI coordinator confirmed that the PSW was provided access to the resident's plan of care and should be aware of the resident's plan of care. [s. 6. (8)]

3. The licensee has failed to ensure that different approaches are considered in the revision of the plan of care because the care set out in the plan has not been effective.

The inspector observed resident #29 wandering in a hallway, and in resident rooms on several occasions.

A review of his/her current plan of care revealed that staff need to provide directional cues, to assist the resident in redirecting from other resident rooms, and in locating his/her own room.

Interview with resident #21's family member confirmed that resident # 29's wandering behaviour disturbs other residents on the unit and the home is not able to manage it properly.

Interview with the PSW and registered nursing staff confirmed that resident #29 is wandering in other resident rooms and eating their food or snacks. The strategies used by the home to prevent the resident's wandering behaviour are not effective.

Interview with the RAI Coordinator confirmed that resident #29 is a wanderer and the plan of care needs to be revised and new strategies should be implemented as the current strategies are not effective. [s. 6. (11) (b)]

4. A review of resident #28's plan of care revealed that the resident is having wandering behaviour and staff need to assist the resident in locating his/her room.

An interview with resident #21's family confirmed that resident #28 is wandering into other resident rooms and lies down in other resident beds. The staff did not succeed in preventing his/her wandering behaviour.

Interview with PSW and registered nursing staff confirmed that the resident has wandering behaviour and likes to lie down in other resident beds. They try to relocate resident #28, however, this strategy is not effective.

Interview with the RAI coordinator confirmed that different approaches should be considered and the plan of care should be revised as resident #28's current strategies are not effective to prevent his/her wandering behaviour. [s. 6. (11) (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, the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, and different approaches are considered in the revision of the plan of because care set out in the plan has not been effective, to be implemented voluntarily.

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ssued on this 12th day of December, 2014

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

riginal report signed by the inspector.