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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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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
Nov 17, 2015	2015_405189_0016	018222-15	Critical Incident System

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 26, September 1,9,10, 11, October 6, 2015.

This Critical Incident Inspection is related to a critical incident the home submitted related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with Director of Care Acting(DOC(A), Manager of Programs and Services, Registered Staff, personal support workers.

During the course of the inspection, the inspector conducted a tour of the nursing unit, observed resident and staff interactions, reviewed clinical health records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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)**

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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Record review of resident #002's progress notes revealed the following:

On three identified dates in May 2015, resident #002 exhibited responsive behaviours towards resident #003.

Interviews with registered staff #118, registered staff #160 and the Director of Care (acting) revealed that the home identified that resident #003 wandering in the unit was a trigger for resident #002's behaviour, and they had implemented 1:1 monitoring for resident #003. Resident #002 was not placed on 1:1 monitoring.

Record review of resident #003's 1:1 monitoring record revealed 1:1 staff was arranged for three identified dates and times in May 2015, two of which were identified as the dates responsive behaviours were exhibited by resident #002 towards resident #003.

There was no 1:1 staffing arranged for resident #003 on the third date identified that resident #002 exhibited responsive behaviours towards resident #003. There were no interventions and monitoring of behaviours in place for resident #002 on this date, and resident #002 acted out towards resident #003.

Interviews with registered staff #118, registered staff #160 and the DOC(A) confirmed that there was no 1:1 safety monitoring in place for resident #002, and no interventions in place to minimize the risk of altercations and potentially harmful interactions between the residents. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care is documented.

Record review of resident #002's progress notes revealed that on an identified date in June 2015, the resident exhibited responsive behaviour, towards a visitor. The home's Dementia Observation system/Behaviour tracking tool was initiated on an identified date in June 2015, and the home's expectation was for the PSWs to document resident #002's behaviours every 30 minutes on day, evening and night shifts.

Record review of resident #002's Dementia Observation system/Behaviour tracking tool during an identified time period between June - July 2015, revealed the resident’s behaviours were not documented every thirty minutes on four identified dates.

Interviews with registered staff #118, PSW #161, and the DOC(A) confirmed that documentation was not completed to track the resident's behaviours on the above mentioned dates. [s. 6. (9) 1.]

Issued on this 11th day of December, 2015

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

Original report signed by the inspector.