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
Dec 9, 2015	2015_405189_0013	018006-15	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

NICOLE RANGER (189)

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): August 28, September 2, 3, 8, 9, 10, 11, 2015.

This Complaint Inspection is related to a complaint regarding continence care, transferring and positioning techniques, reporting and complaints, and Residents' Bill of Rights.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), registered staff, personal support workers, nursing clerk, family member.

During the course of the inspection, the inspector conducted a tour of the 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:
Continence Care and Bowel Management
Personal Support Services

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:
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 following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On an identified date in January 2015, resident #004 was assigned to personal support worker PSW#102. The inspector observed via home's video surveillence the resident was left unattended by the PSW for 2.5 hours. Interview with resident's family revealed that upon arrival into the resident's room, he/she found the resident's bed linen and continent brief to be heavily soiled and not changed. The family member also reported to the inspector that the room window was left open , the room was cold, and the resident was shaking due to the cold weather. Family member reported to the inspector PSW # 102 reported to the family member that the room window was left open because the PSW was called away.

Record review revealed that the resident requires two person physical assistance with transfer and is unable to get out of bed on own.

Interview with RN #108 and the Acting Director of Care(DOC(A)) confirmed that the family member did express concern that the room window was open on a cold winter day and that PSW# 102 confirmed that he/she did leave the room window open. Interview with the Administrator and DOC(A) revealed that the home's expectation is that residents are properly sheltered and cared for in a manner consistent with his or her needs, and confirmed that resident #004 did obtain some discomfort with the room window opened. [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 following rights of residents are fully respected and promoted: Every resident has the 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 #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. (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).

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.

Review of the plan of care dated January 2015, reveals that the resident requires two person physical assistance with mechanical aid for transfers.

On an identified date in January 2015, resident #004 was assigned to PSW #102. PSW #102 was observed via video surveillance to bring in a standing lift into the resident's room and then wheeling the resident out of the room. The inspector did not observe a second staff member entering the room to assist with the transfer.

Interview with the family member revealed that on the identified date, PSW#102 transferred the resident by himself without a second person assisting. Interview with RN #103 and PSW #106 who worked on the identified date, confirmed they did not assist PSW #102 with the transfer.

Review of the video surveillance with Administrator and DOC confirmed a second person was not observed entering the room to assist with transfers and the PSW transferred the resident without a second person assisting. The DOC confirmed that the care was not provided as set out in the plan of care. [s. 6. (7)]

2. Video surveillance of an identified date, reviewed by the inspector revealed resident #004 was assigned to PSW #102.

Inspector observed via video surveillance for 2.5 hours the resident was left unattended by the PSW. Interview with resident's family revealed that upon arrival into the resident's room, he/she found the resident's bed linen and continent brief to be heavily soiled and not changed.

Interview with DOC confirmed that a meeting was held with PSW #102 during which he/she confirmed leaving the resident in bed and the room window was left opened.

Review of video surveillance with Administrator and DOC confirmed that the resident was left unattended in bed by the PSW staff and was not changed for a period of 2.5 hours. [s. 6. (7)]

3. The written plan of care for resident #004 states that the resident requires incontinence checks and toileting before and after meals due to bladder/bowel incontinence and immobility. The resident is dependent on the staff for toileting.

On an identified date in September 2015, the inspector observed resident #004 in her wheelchair from 11:00 a.m to 2:35 p.m.

The inspector did not observe the resident to be toileted before or after lunch. An interview with the assigned PSW#110 stated that he/she and PSW #104 assisted the resident to the toilet after lunch, however PSW #104 provided conflicting information as he/she reported he/she did not assist the resident to the toilet after lunch. Interview with RN #103 confirmed that the resident is on a toileting schedule and the resident is to be toileted before and after meals. [s. 6. (7)]

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, to be implemented voluntarily.

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.