Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2021	2021_891649_0023	017379-21	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

JULIEANN HING (649), STEPHANIE LUCIANI (707428)

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 18, 19, 22, 23, 24, 25, 26, 29, December 1, 2, off-site on November 30, December 15 and 17, 2021.

The following intake was completed during this complaint inspection.
Log #017379-21 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC)/Nurse Consultant, Food Services Manager (FSM), Registered Nurse (RN), Registered Dietitian (RD), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

During the course of the inspection the inspectors observed staff to resident interactions, reviewed residents' clinical records, and staffing schedules.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 written plan of care for the resident set out the planned care for the resident.

A complaint was reported to the Ministry of Long-Term Care (MLTC) alleging that the resident head of their bed was not in the correction position.

The resident's written care plan indicated that they had difficulty with breathing related to a specific medical condition. There was no intervention in the resident's written plan of care related to the position of the head of bed (HOB) except during meals they should be positioned at 90 degrees. A sign posted in the resident's room provided further staff direction. Staff told the inspector that the posted sign was still current and what staff had been following. This posted intervention was not updated in the resident's written plan of care.

This concern was brought to the acting Director of Care's (DOC) attention who acknowledged that the resident's written plan of care should have been updated with the direction on the posted sign since this was what staff followed.

Sources: review of resident's clinical records, interview with acting DOC, and other staff. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The resident's care plan indicated that they had difficulty with breathing related to a specific medical condition, and that their HOB should be in a specific position. This intervention was updated in the resident's written care plan in the fall of 2021. The updated intervention was not based on the resident's assessed needs and preferences, and contradicted the posted sign in the resident's room .

During this inspection the resident was observed in bed with their HOB elevated.

The Registered Practical Nurse (RPN) acknowledged that the resident's HOB should be elevated 45 degrees or more, and that the care plan needed to be updated. They told the inspector that the posted sign in the resident's room reflected the resident's family wishes, was still current, and what staff had been following.

The RPN stated that the resident's care plan was incomplete as it did not specify when the resident's HOB should be elevated to a specific degree. They explained that when the resident was sleeping the HOB should be at a specific degree both when eating and not eating.

This concern was brought to the acting DOC's attention who advised that an assessment should have been completed for the HOB but was unable to locate the completed assessment. They acknowledged that the care plan updated in 2021 should have been clearer.

Sources: review of resident's clinical records, interview with RPNs, and acting DOC #109. [s. 6. (2)]

3. The licensee has failed to ensure that the resident, the resident's substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of three resident's plan of care.

A complaint was reported to the MLTC that the resident's substitute decision-maker (SDM) was not informed of their weight loss.

The resident experienced a significant weight loss during an identified period.

The resident's clinical record in Point Click Care (PCC) during the above period did not indicate any documentation that the resident's SDM was informed of their significant weight loss during this period.

This concern was brought to the acting DOC's attention who acknowledged that the resident's SDM should have been informed of the resident's significant weight loss to allow an opportunity to participate in the development and implementation of the plan of care.

Sources: review of resident's clinical records, interview with acting DOC, and other staff. [s. 6. (5)]

4. As a result of non-compliance identified for the above resident, the sample was expanded to another resident.

The resident experienced significant weight loss which was acknowledged by the RD.

The resident's progress notes were reviewed, and no documentation was noted that the resident's SDM was notified about the significant weight loss for the above mentioned period. Registered Dietitian (RD) acknowledged that there was no documentation that the resident's SDM was notified about their significant weight loss.

The RD, Acting DOC and RPN acknowledged that when the resident had a significant weight loss, the SDM should have been notified, and that registered staff were responsible for notifying the SDM.

Sources: Resident's progress notes, weight summary report, and interviews with acting DOC, RD and RPN. [s. 6. (5)]

5. As a result of non-compliance identified for the above resident the sample was expanded to a third resident.

The resident experienced a significant weight loss over the period of one month.

The resident’s clinical record in PCC was reviewed and there was no documentation that the resident's SDM was informed of the significant weight loss.

The RD confirmed that there was no documentation that resident's SDM was notified of their significant weight loss by the previous RD. Acting DOC acknowledged that the resident’s SDM should have been informed of the resident’s significant weight loss.

Sources: review of resident’s clinical records, interview with RD and acting DOC. [s. 6. (5)]

6. The licensee has failed to ensure that the provision of care set out in two resident’s plan of care was documented.

A complaint was reported to the MLTC related to concerns about the resident’s weight loss.

In August 2020 the resident was assessed as high nutritional risk. Their food and fluid intake at meals were not documented five times in March, 24 times in April, and 21 times in May and June 2020, when they experienced significant weight loss between March and July 2020.

The RPN acknowledged that the resident’s food and fluid intake should have been documented. This concern was brought to the acting DOC’s attention who stated as per policy this should have been completed.

Sources: review of resident’s clinical records, interview with RPN and acting DOC. [s. 6. (9) 1.]

7. As a result of non-compliance identified for the above resident the sample was expanded to another resident.

In February 2020 resident was assessed as high nutritional risk. Their food and fluid intake at meals were not documented four times in March, 24 times in April, 18 times in

May, 21 times in June, and 4 times in July 2020.

The above gap in the resident's food and fluid intake documentation was brought to Acting DOC's attention. They advised that each resident should have had their food and fluid intake documented after their meals.

Sources: review of resident's clinical records, interview with acting DOC. [s. 6. (9) 1.]

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 there is a written plan of care for each resident that sets out the planned care for the resident,
ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, and
ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's resident weight monitoring system was complied with for two residents.

O. Reg. 79/10, s. 68. (2) (e) (i) directs the licensee to ensure that their nutrition and hydration programs include a weight monitoring system to measure and record residents' weights on admission and monthly thereafter.

Specifically, staff did not comply with the home's weight monitoring policy #C-25 last updated May 3, 2019, that directed staff to weigh residents monthly by the seventh of the month.
(i) No monthly weight was recorded for the first resident in May 2020 during which time the resident had experienced a significant weight loss.
(ii) As a result of non-compliance identified for the above resident the sample was expanded to another resident. Record review indicated no monthly weight was recorded for the resident in April and May 2020.

The RD confirmed that no monthly weight was recorded for the first resident in May 2020 and for the second resident in April and May 2020. This concern was brought to the acting DOC who acknowledged that the two residents monthly weights should have been recorded.

Sources: review of two resident's clinical records, interview with RD, and acting DOC. [s. 8. (1)]

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 plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's weight changes were assessed using an interdisciplinary approach, and that actions were taken, and outcomes were evaluated.

According to the resident's care plan they were on a weight reduction diet.

The resident experienced a significant weight loss. The previous RD was aware of the resident's weight loss when they started to lose weight. The next month the RD documented that the resident was within their ideal body weight (IBW) but left the resident on a weight reduction diet for two and a half months. No assessment was completed in May 2020 and no monthly weight was recorded. At the end of of the following month the previous RD documented that the cause of the resident's weight loss was unclear, and they discontinued the resident's weight reduction diet. For the next two months the resident continued to experience weight loss, and there was no documentation of a reassessment.

The RD acknowledged that the resident was not assessed by the previous RD when they continued to experience significant weight loss. They acknowledged that the resident was left on a weight reduction diet for the two and a half months after it was documented by the previous RD that they were within their IBW.

This concern was brought to the acting DOC's attention who acknowledged that the resident should have been assessed when they had experienced a significant weight

loss.

Sources: review of resident's clinical records, interview with RD and acting DOC. [s. 69.]

2. As a result of non-compliance identified for the above resident the sample was expanded to another resident.

Record review indicated that resident experienced a significant weight loss.

The resident was not assessed by the RD when they experienced a significant weight loss.

The RD acknowledged that the resident was not assessed when they experienced a significant weight loss.

The Acting DOC confirmed that the resident should have been assessed when they experienced a significant weight loss.

Sources: review of resident's clinical records, interview with RD and acting DOC. [s. 69.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

Issued on this 5th day of January, 2022

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

Original report signed by the inspector.