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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 8, 2016	2016_377502_0010	034871-15, 018260-16	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

JULIENNE NGONLOGA (502)

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): June 22, 27, 28, 29, 2016.

These complaint inspections are related to pain management and insufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), assistant Nurse Manager (ANM), Manager of Clinical Informatics, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), food service manager (FSM), physiotherapist (PT), physiotherapist aide (PTA), residents, family members.

The inspectors also observed resident to staff interactions, resident to resident interactions, provision of care, reviewed clinical and home records, staff training records, staff schedules, home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Pain
Personal Support Services
Sufficient Staffing

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 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.

On a specific date, Ministry of Health and Long-Term care Action-Line received an anonymous complaint. The complainant voiced concerns related to insufficient staffing and residents not receiving proper care.

On a specific date and time, the inspector observed resident #025 being transferred with a mechanical lift from the wheelchair to the commode by PSW #110. The PSW completed the transfer without assistance.

Review of the resident #025's most recent written plan of care revealed the resident required two person total assistance during the entire toileting process, related to an identified medical condition.

Interview with PSW #110 confirmed he/she had used the lift to transfer resident #025 without assistance because the second staff was not available to assist with the transfer. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On a specific date, Ministry of Health and Long-Term care ActionLine received a complaint. The complainant voiced a concern related to pain management in the home.

Review of resident #022's progress notes revealed the following:
- On a specific date, resident #022 complained of pain on an identified body part, initial intervention included a reminder to the resident to lower down the head of his/her bed.
- On a specific date and time, resident #022 complained of pain on an identified body part, a second intervention was suggested.
- On a specific date and time, resident #022 complained again of pain on an identified body part, physician was notified by phone. The Physician ordered an X-Ray and changed resident #022's medication.
- On a specific date, the physician assessed the resident and documented that the above identified body part was very painful since a specified date, and an identified medication was started but not effective.

Review of resident #022's plan of care revealed a pain assessment using the clinically appropriate assessment instrument specifically designed for this purpose was not completed during the above mentioned period of time.

Interview with RPN #152 confirmed he/she had not assessed resident #022 when the resident complained of pain on his/her identified body part. Interview with lead of pain management program and ANM #117 confirmed resident #022 was not assessed using the home's pain assessment tool available in the home's documentation system, Point Click Care. [s. 52. (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 when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 16th day of August, 2016

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

Original report signed by the inspector.