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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2017	2017_324535_0021	025156-17	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

VERON ASH (535)

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): November 27, 28, 2017.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DON), Nurse Manager (NM), Associate Nurse Manager (ANM), Registered Dietitian (RD), Physiotherapist (PT), registered staff (RN RPN), personal support worker(PSW), Substitute Decision Makers (SDMs).

During the course of the inspection, the inspector conducted observation of staff to resident interactions, provision of care, conducted interviews, record review of health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **4 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. 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 staff used safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health (MOH) received a critical incident report related to resident #001 who fell and was transferred to hospital with a significant change in health condition.

According to the critical incident, resident #001 climbed out of bed in his/her room and fell on the floor and onto the fall mattress which was set in place. During an interview, registered staff #106 stated that he/she conducted a fall assessment and discovered that the resident was complaining of pain in an identified area. The RPN confirmed calling the physician, the substitute decision maker, then 911 to transfer the resident to acute care hospital for further assessment and treatment of an injury.

During separate interviews, registered staff #106 and PSW #104 confirmed transferring the resident from the fall mattress onto the resident's bed because the resident asked to be returned to bed. During the interview, RPN #106 stated that he/she saw that the resident was trying to get up; and although he/she knew that maybe they should not have moved the resident, the PSW and RPN supported the resident to transfer on top of the bed.

During an interview, Nurse Manager and falls prevention lead #103 stated the staff saw that the resident was trying to move back onto the bed; therefore the PSW and RPN transferred the resident back to the bed. Furthermore, the Nurse Manager stated that he/she had a discussion with both staff and informed them that the resident should not have been moved because it was uncertain the level of injury the resident might have sustained as a result of the fall. [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 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 if the resident was being reassessed and the plan of care was being revised because care set out in the plan of care had not been effective, different approaches were considered in the revision of the plan of care.

The Ministry of Health (MOH) received a critical incident report related to resident #001 who fell and was transferred to hospital with a significant change in health condition.

According to the critical incident, on an identified date, resident #001 climbed out of bed in his/her room and fell on the floor and onto the fall mattress; the report listed the incident of climbing out of bed as a responsive behavior. Record review revealed that the resident was enlisted in the home's falls prevention program; and had interventions in place prior to the fall.

During an interview, PSW #104 stated that while conducting rounds that morning, he/she heard resident #001 calling for help and attended the room where the resident was seen sitting up at the side of the bed on the fall mattress. The PSW also confirmed that he/she did not hear an alarm sound prior to or upon discovering the resident on the floor. The PSW noticed that the alarm was located on the resident's bed; and stated that usually the string was clipped on to the resident's clothing while he/she was sleeping; but it was obviously removed prior to leaving the bed. The PSW confirmed that if the resident knew the alarm was on his/her clothing, he/she would remove the alarm as was done in the past.

During an interview, registered staff RPN #106 stated that at the time of the fall, a fall mattress was in place on the floor; however, the resident did not have the fall alarm attached because the resident was able to unhook the alarm from his/her clothing. The RPN further stated that the fall alarm was not effective because the resident was able to unhook the alarm; and that hearing the alarm might have alerted the staff to attend to the resident's room immediately while the resident was attempting to leave the bed.

During an interview, Nurse Manager (NM) and falls prevention Lead #103 confirmed that the resident was at high risk for falls especially since she he/she had previous falls in the past. In addition, the NM confirmed that the resident should always wear the fall alarm while in bed; and that he/she was aware that the resident could unhook the alarm from his/her clothing. [s. 6. (11) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The Ministry of Health (MOH) received a critical incident report related to resident #001 who fell and was transferred to hospital with a significant change in health condition.

According to the critical incident (CI), on an identified date, resident #001 climbed out of bed in his/her room and fell on the floor and onto the fall mattress. The CI also listed the incident of climbing out of bed as a responsive behavior. During an interview, registered staff RPN #106 confirmed that the resident experienced an unwitnessed fall in his/her room; and that the falls assessment and head injury routine were completed; however he/she could not recall completing the documentation of the head injury routine assessment.

Record review of the point click care documentation records revealed that head injury routine was not documented by RPN #106.

During an interview, Nurse Manager and falls prevention lead #103 stated that the head injury routine should have been completed for the unwitnessed fall; and confirmed that the resident's head injury routine was not documented in the PCC documentation record. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was informed no later than three business days after the occurrence of an incident which caused an injury for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

The Ministry of Health (MOH) received a critical incident report related to resident #001 who fell and was transferred to hospital with a significant change in health condition.

According to the critical incident, on an identified date, resident #001 climbed out of bed in his/her room and fell on the floor and onto the fall mattress which was set in place. During an interview, registered staff #106 stated that he/she conducted a fall assessment and discovered that the resident was experiencing pain in the affected area. The RPN stated that he/she called the physician, the substitute decision maker, then called 911 to arrange for the resident to be transferred to acute care hospital for further assessment and treatment.

Record review revealed that on an identified date, the substitute decision maker contacted the home and reported to registered staff #106 that the resident was admitted to hospital and was awaiting a surgical procedure. Record review of the progress notes revealed that on an identified date, the Nurse Manager and falls prevention lead #103 spoke directly with the resident's substitute decision maker; and was updated that the resident required a surgical procedure.

During an interview, Nurse Manager #103 stated that the critical incident was submitted to the Director beyond the required date, because he/she was unsure if the resident would have had significant changes to his/her health condition; and was therefore awaiting an assessment by the therapist after the resident returned to the home.

During an interview, the home's Director of Nursing #101 confirmed that the resident's health condition was significantly affected by the fall; and therefore a critical incident should have been sent to the Director with the required three business days. [s. 107. (3.1)]

Issued on this 19th day of December, 2017

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

Original report signed by the inspector.