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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2019	2019_630589_0008	000529-18, 029317-18, 004773-19	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

JOANNE ZAHUR (589)

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): March 4, 5, 8, (on-site) and March 6, 7 and 12 (off-site), 2019.

The following intakes were completed during this inspection:
-Log #004773-19 related to CO #001, O. Reg. 79/10, r. 36, unsafe transferring techniques,
-Log #029317-18 related to unsafe transferring, and
-Log #000529-18 related to falls prevention and unsafe transferring.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Registered Physiotherapist (RPT), and residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, and the provision of care, reviewed health records, the home's internal investigation notes, staff personnel file and training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2018_714673_0008	589

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 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 use safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health and Long Term Care (MOHLTC) received critical incident system (CIS) report for a near miss fall incident. The CIS report indicated that while resident #002 was being transferred with a mechanical lift their health status changed and staff #104 then lowered resident #002 down to the floor to prevent any injury.

A review of resident #002's care plan in place at the time of the above mentioned incident indicated they required the assistance of two staff using a mechanical lift for transfers.

A review of resident #002's documentation notes in point click care (PCC) the home's electronic documentation system indicated an assessment completed by staff #106 had not indicated any apparent injuries. Five days later, resident #002 presented with altered skin integrity and was sent to hospital. On the same day the hospital confirmed resident #002 had sustained an injury.

Staff #104 no longer works in the home however, in a telephone interview stated they had used the mechanical lift unassisted by a co-worker when transferring resident #002 and during the transfer, resident #002's health status changed so they slowly lowered them to the floor. A review of the home's internal investigation notes indicated staff #104 had admitted to transferring resident #002 unassisted. Staff #104 further acknowledged this had not been the first time they had completed resident transfers with a mechanical lift unassisted. A review of staff #104's personnel file indicated that upon being hired by the long term care home (LTCH), they had received general orientation that included education related to lifts and transfers, and safe resident handling. On two alternate dates in 2017, staff #104 also completed on-line education modules related to lifts and transfers, and safe resident handling.

During interviews, staff #102 and #112 stated they had observed staff #104 completing resident transfers with a mechanical lift unassisted prior to the above mentioned incident. Staff #112 further stated they had observed staff #104 continue to complete unsafe transfers after the above mentioned incident, which they had reported. Staff #102 stated when they had been called to resident #004's room by staff #104 they had observed the resident on the floor. Staff #102 indicated they had not been been asked to assist with the mechanical lift transfer but rather to manually assist transferring resident #002 to bed after the incident. Staff #102 refused and called the registered practical nurse to assess the resident.

A further review of resident #002's PCC documentation notes indicated that five days later, resident #002 was transferred to hospital related to altered skin integrity where they were diagnosed with an injury. As a result of this diagnosis, staff #104 was interviewed by the management staff and provided with one to one (1:1) education on transfers using a mechanical lift. The objectives of this education included:
-two person assist during transfer using a mechanical lift,
-safe handling of residents, and
-show how to operate the sit to stand and hoyer lifts.
Staff #104 was also required to read policies relevant to the above mentioned incident involving resident #004 and to sign them, acknowledging they understood what they had read.

During an interview, former staff #118 stated that 10 days after the initial incident, staff #112 reported to them that staff #104 had been observed completing transfers with a mechanical lift unassisted. As a result of this, an investigation was started and staff #104 was put on administrative leave for an identified period of four days, and then was subsequently terminated from the LTCH. Staff #118 acknowledged that even though staff #104 had been provided with education related to mechanical lift transfers and safe transferring/positioning techniques they had failed to use safe transferring and positioning devices or techniques when assisting residents.

The severity of this finding was a level 3, indicating actual harm/risk. The scope was a level 1, indicating this was isolated. A review of the home's compliance history was a level 4, indicating compliance order (CO) #001 under O. Reg. 79/10, r. 36 had been served in report #2018_714673_0008 on August 23, 2018, with a compliance date of November 19, 2018. According to the judgement matrix, a compliance order (CO) is warranted, however, this incident occurred prior to CO #001 being served, and it has been confirmed through the inspection that CO #001 related to unsafe transferring has

been addressed by the home and noted to be in compliance. A written notification (WN) is being issued. [s. 36.]

Issued on this 14th day of March, 2019

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

Original report signed by the inspector.