Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
July 8,9,12,13, 2010	2010_104_8609_06Jul121420	Complaint: Line 127

Licensee/Titulaire
Ina Grafton Gage Home of Toronto
40 Bell Estate Road, Scarborough, ON, M1L 0E2
Fax: 416-422-1613

Long-Term Care Home/Foyer de soins de longue durée
Ina Grafton Gage Home
40 Bell Estate Road, Scarborough, ON, M1L 0E2
Fax: 416-422-1613

Name of Inspector(s)/Nom de l'inspecteur(s)
Judy Macaulay, Inspector #104

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the care and services provided to an identified resident.

During the course of the inspection, the inspector spoke with the Administrator, Director of Care and Assistant Director of Care, several registered nursing and PSW staff.

During the course of the inspection, the inspector reviewed resident records, observed residents and resident rooms.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Dignity, Choice and Privacy

Falls Prevention

Nutritition and Hydration

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the Long-Term Care Homes Program Manual criterion: B5.2: The care and services provided to each resident shall be documented in the resident's record according to facility policies and procedures.

Findings:

1. The home's policy "*Criteria for the Use of Restraining Devices" RC-0616-02, June 8, 2010,* identified: "*The PSW shall document on the "restraint Record" the hourly checks that are being done".*
   - An identified resident's Restraint Record was undated and no evidence of "safety check done" was documented for a period of seven days on the day or evening shifts.
   - Interviewed PSW staff were not aware of the requirements for restrained residents to be monitored hourly.
   - Hourly monitoring of this restrained resident was not documented on the Restraint Record according to the facility policies and procedures.
2. The home's policy "*Criteria for the Use of Restraining Devices" RC-0616-02, June 8, 2010*, identified: *"Residents are to have the restraint released and be repositioned every 2 hours. PSWs are to initial all documentation for the shift during which they observed and did nursing interventions with their resident."*
   - An identified resident's Restraint Record was undated and periods of four hours without repositioning were noted on the several occasions.
   - The Restraint Record of another identified resident did not consistently reflect repositioning every two hours.
   - Interviewed PSW staff were not aware of the requirements for restrained residents to be repositioned every two hours.
   - Repositioning of restrained residents every two hours was not documented on the Restraint record according to the facility policies and procedures.
3. Documentation on the food and fluid intake records was not accurate.
   - There were two food and fluid intake records for an identified resident which noted conflicting documentation of intake amounts for breakfast, lunch and supper meals for the same day.
4. Documentation on the Restraint Record was not complete.
   - The Restraint Record of an identified resident did not identify the month in use, and the year was identified as 2009 rather than 2010.

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WN #2: The Licensee has failed to comply with the Long -Term Care Homes Program Manual criterion: A1.11(6)iii Every resident has the right to have the opportunity to participate fully in making any decision and obtaining an independent medical opinion concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a home.

Findings:

1. An identified resident's Advanced Directive preference was communicated incorrectly to the hospital upon their transfer to hospital.

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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. J Macaulay, LTCH Inspector - Nursing
Title: Date:	Date of Report: April 13, 2011