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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Nov 17, 2015	2015_405189_0014	015043-15	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

NICOLE RANGER (189)

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): August 26, 28 and September 1, 2, 2015.

This Complaint Inspection is related to a complaint regarding transferring and positioning techniques and plan of care.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care Acting(DOC(A), Physiotherapist (PT), Registered Staff, personal support workers (PSW), personal support worker students.

During the course of the inspection, the inspector conducted a tour of the unit, observed resident and staff interactions, reviewed clinical health records, and relevant home policies and procedures.

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the written plan of care for resident #001 dated June 2015, states that the resident requires 2 person extensive assistance for transferring.

On an identified date in June 2015, PSW #102 reported to registered staff #103 that he/she found the resident in bed with a bump on an identified area on the face. The resident was brought into the dining room for breakfast, and the resident was observed to have bruising on two identified areas on the face. The resident was assessed by the Nurse Practitioner and Physician.

Interviews with PSW students #158 and #159, who were assigned to work with PSW #102 on the identified date, reported to the inspector they were in the room when they observed PSW #102 use the standing lift on his/her own to transfer the resident out of bed into the wheelchair. The PSW students reported that they did not assist PSW #102 with the transfer.

Interview with registered staff #103, who worked on the identified date, reported to the inspector that after the incident, he/she interviewed the PSW students who confirmed that PSW #102 transferred the resident on his/her own.

Interview with Physiotherapist #130, Registered staff #103, PSW #110 and Director of Care(Acting)confirmed that the resident was a 2 person extensive assistance for transferring and did not require the use of the lift on the identified date. The Administrator and DOC(A) confirmed that the care set out in the plan of care was not provided to resident #001. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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.

Review of the written plan of care for resident #001 dated June 2015, states that the resident requires 2 person extensive assistance for transferring.

On an identified date in June 2015, PSW #102 reported to registered staff #103 that he/she found the resident in bed with a bump on an identified area of the face. The resident was brought into the dining room for breakfast, and the resident was observed to have bruising on two identified areas on the face. The resident was assessed by the Nurse Practitioner and Physician.

Interviews with PSW students #158 and #159, who were assigned to work with PSW #102 on the identified date, reported to the inspector they were in the room when they observed PSW #102 use the standing lift on his/her own to transfer the resident out of bed into the wheelchair. The PSW students reported that they did not assist PSW #102 with the transfer. PSW students reported that they were directed to take the standing lift out of the room by PSW #102, while PSW#102 continued to provide care to the resident.

Interview with registered staff #103, who worked on the identified date, reported to the inspector that after the incident, he/she interviewed the PSW students who confirmed that PSW #102 transferred the resident on his/her own, and that PSW #102 did not report to what happened during his/her care.

Video surveillance of the identified date reviewed by the inspector revealed resident #001 was assigned to PSW #102 with 2 students assisting. Inspector observed PSW #102 and students #158 and #159 entering in and out of the room on multiple occasions, and a standing lift was observed taken out of the room by the students, and a short time after the resident is wheeled out of the room by PSW #102.

Interview with Physiotherapist #130, Registered staff #103, PSW #110 and DOC(A) confirmed that the resident was a 2 person extensive assistance for transferring and did not require the use of the lift on the identified date. The Administrator and DOC(A) confirmed that PSW #102 did not use safe transferring techniques when assisting the resident, and the resident sustained an injury while in the care of PSW #102. [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.

Issued on this 11th day of December, 2015

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

Original report signed by the inspector.