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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Feb 1, 2017	2016_334565_0009	018980-16	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

MATTHEW CHIU (565), ADAM DICKEY (643), ANGIE KING (644), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), SUSAN SEMEREDY (501), TILDA HUI (512)

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): June 14, 15, 16, 17, 20, 22, 23, 24, 27, 28, 29, and 30, 2016.

During the course of the inspection, the following Critical Incident Intakes were inspected:
- 003668-14, 017045-16: related to resident fall with injury

- 009295-14, 012753-15, 021219-15, 034916-15, 008769-16, 018951-16: related to staff to resident physical abuse
- 002560-15, 026523-15, 008582-16, 008904-16, 018980-16: related to staff to resident verbal abuse
- 004654-15, 020172-15, 030868-15, 006351-16: related to staff to resident neglect
- 032374-15, 015113-15, 003209-16, 013080-16: related to resident to resident abuse
- 002890-16: related to resident injury with unknown cause
- 007790-16: related to improper care of a resident
- 008906-16: related to responsive behaviours

During the course of the inspection, Complaint Intake #018260-16 was inspected by inspector #502 under inspection #2016_377502_0010. A finding of non-compliance is being issued as part of the RQI inspection under LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) (a) related to resident #022.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Managers (NM), Director of Support Services (DSS), Program Manager (PM), Manager of Clinical Informatics (MCI), Dietary Supervisor (DS), Dietary Consultant (DC), Maintenance Lead Hand (MLH), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Physiotherapy Aide (PTA), Nursing Consultant (NC), Psychogeriatric Resource Consultant (PRC), Recreation Assistant (RA), Cook, Dietary Aides (DA), Housekeeping Aides (HA), Nursing Clerk, Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **3 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Review of a Critical Incident System (CIS) report revealed on an identified date, resident #041 was noted with a specified injury. The resident had not been able to explain how he/she sustained the injury. The resident was discharged from the home on an identified date, about one month later.

Review of a Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment indicated resident #041 needed a specified number of staff assistance for transfer. Review of the resident's written plan of care revealed the resident needed the specified number of staff with a specified level of assistance for transfer due to his/her specified medical condition. Review of the PSW's documentation sheet for an identified month revealed the resident had used the specified assistance. However the record failed to reveal as to what level of assistance have been provided to the resident and how many staff were involved during the transfer on the day before staff had noted resident #041's specified injury.

Interview with PSW #108 revealed on the day before staff had noted resident #041's specified injury, he/she had transferred the resident alone instead of the specified number of staff required. Further the PSW confirmed he/she had been transferring the resident alone each time he/she had been assisting the resident. The staff member also revealed he/she had not considered the fact that the other PSWs had been providing the specified transfer assistance to the resident. PSW #108 confirmed he/she was aware of the resident's specified medical needs for transfer, but he/she used own techniques when transferring the resident.

Interview with the DON confirmed PSW #108 neglected resident #041 when the PSW failed to provide the resident the assistance required for safe transferring. [s. 19. (1)]

2. Review of a CIS report revealed on an identified date, resident #042 had reported PSW #118 to the licensee because the PSW made some specified inappropriate verbal comments to the resident during an identified activity of daily living (ADL) and that made the resident very upset.

Interview with resident #042 confirmed on the identified date, the resident wished PSW #118 to provide a specified care during the identified ADL. The PSW had ignored resident's request and made the inappropriate verbal comments to the resident.

Interview with PSW #118 confirmed he/she assisted resident #042 during the identified

ADL on the identified date. The resident became upset because the PSW refused to provide the specified care.

Further, the PSW confirmed that he/she made a statement to the resident in order to calm him/her down. Although the PSW found no bad meaning in his/her statement, the resident became upset about the statement. The PSW acknowledged that he/she would not use the same approach for any other resident however he/she did not go back to clarify with the resident what made the resident upset about PSW's statement.

Interview with the DON revealed the resident might have not heard what the PSW had said exactly. After the DON heard the PSW statement from the interview with the inspector, the DON confirmed that it was not the way staff should have spoken to the resident and PSW #118's approach was not appropriate. [s. 19. (1)]

3. Review of a CIS report revealed PSW #121 identified a specified altered skin integrity on resident #046 and reported it to the nurse in charge.

During the home's investigation, the resident had stated an identified sharp object could have caught the skin that resulted in the specified altered skin integrity. The resident had also indicated that the staff had been rough when they provide care to him/her. Staff searched for the identified sharp object and found none. The resident was given support and re-assurance that staff will be gentler when they provide care to him/her.

Review of resident #046's written plan of care revealed the resident had specified medical conditions and required assistance for ADLs due to pain in certain specified areas.

Interview with the resident confirmed he/she had pain and it had been painful when the staff provided care as they had been too rough during assistance with an identified ADL.

Interview with PSW #121 confirmed the resident had always complained of pain when they provided care. Further the PSW confirmed he/she knew the resident had received pain medication some time during the day. The staff member also confirmed he/she had not communicated to the nurse in charge about the daily complaints of pain because as the PSW went to tell the nurse, the resident stated he/she had no pain.

Interview with the NM confirmed the resident had been complaining of PSW #121 being rough while providing personal care and the home had taken specified action to the staff.

Further the NM confirmed the staff is expected to be gentle when providing care to the residents and to consider the resident's health condition and should have reported to the nurse that the resident was still complaining of pain despite receiving analgesics. PSW #121 neglected resident #046 when the PSW failed to acknowledge the resident's complaints of pain and not reporting the complaints to the registered staff. [s. 19. (1)]

4. Review of a CIS report revealed an allegation of staff to resident neglect was reported on an identified date. Resident #061 was left unattended in the washroom for an extended period of time.

Review of resident #061's care plan revealed the resident had physical impairments and required specified assistance for ambulation and toileting for safety.

Resident #061 was unavailable for interview, and the inspector interviewed resident #062 who was resident #061's roommate. Resident #062 recalled the above mentioned incident and he/she could not recall how long resident #061 stayed in the washroom.

The inspector interviewed PSW #143 who stated that he/she did toilet resident #061 on the identified date. The PSW recalled toileting resident #061 and waited outside the washroom door until the resident was ready to be transferred, about five minutes later. According to PSW #143, he/she received assistance from RPN #126 who was in the same room providing care to the resident's roommate. The inspector interviewed RPN #126 who insisted that resident #061 was provided continence care in bed. The inspector interviewed staff #167 who provided information on the PSW flow sheet on Point-of-Care (POC) to indicate that resident #061 was toileted on the identified date at an identified time.

Based on the statement provided by PSW #143 that he/she did toilet resident #061, supported by the POC documentation, and the time that the resident was found still in the washroom, there is evidence to indicate resident #061 was left in the washroom for the identified period of time.

Interview with the DON confirmed resident #061 was left on the toilet on the identified date, and that PSW #143 had neglected to assist the resident back to bed before he/she finished his/her shift duty. [s. 19. (1)]

5. Review of a CIS report revealed an allegation of staff to resident abuse was reported on an identified date. Resident #061 rang the call bell requesting a specified care. PSW

#144 responded to the call and went into the resident's room together with an identified PSW. According to the resident's roommate, resident #062, he/she heard PSW #144 responded to resident #061 in a manner that made the resident upset and heard a slapping sound. Resident #062 intervened and both PSWs left the room. As PSW #144 passed by resident #062's bed when leaving the room, resident #062 heard an inappropriate verbal comment from PSW #144 towards resident #062.

On the same day, both residents reported the incident to PSW #103. PSW #103 involved the day charge nurse who then in turn notified the DON. Both residents were interviewed by the DON and both stated they were very upset with the action of PSW #144. The home had completed an investigation and taken identified actions to both PSWs.

The inspector interviewed resident #061's roommate as resident #061 was unavailable for interview. Resident #062 confirmed that PSW #144 did yell at resident #061 and did not provide the specified care to resident #061 as requested. Resident #062 did not witness any inappropriate physical force was applied towards resident #061. During the interview, resident #062 confirmed that PSW #144 had made the inappropriate verbal comment towards him/her while on his/her way out of the room.

Interview with PSW #144 indicated that resident #061 was not provided with the specified care as requested when PSW #144 went into the resident's room to respond to the call bell. However, PSW #144 denied the other above mentioned allegations towards residents #061 and #062.

Several attempts were made but failed to interview the identified RPN and the identified PSW on duty on the unit when the alleged abuse/neglect took place.

Interview with the DON confirmed PSW #144 had neglected to provide care to resident #061 to meet the resident's specified care needs. Based on the evidence provided by resident #062, the DON confirmed the finding of abuse to residents #061 and #062 by PSW #144.

The severity of the non-compliance and the severity of the harm is actual.

The scope of the non-compliance is isolated to residents #041, #042, #046, #061 and #062.

A review of the Compliance History for the last three years revealed no non-compliances

related to the Long-Term Care Homes Act, 2007, s. 19. (1). [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #022 that set out the planned care for the resident.

On an identified date, MOHLTC ActionLine received a complaint related to the management of a specified symptom for residents in the home.

Review of resident #022's progress notes revealed on an identified date, the resident complained of the specified symptom. Further review of the resident's progress notes revealed:
- Two days later, the PT recommended a treatment for the resident's specified symptom. The physician assessed the resident and documented his/her specified symptom and an identified medication started but not effective.
- Five days later, the physician recommended a specified procedure and a specified intervention to alleviate the specified symptom.

Review of the resident #022's most recent written plan of care revealed the above recommendations and interventions had not been included.

Interview with PT #109 revealed he/she assessed the resident and recommended the above mentioned treatment. PT #109 confirmed he/she had communicated verbally to the nursing staff and had not revised the written plan of care.

Interview with RPN #152 and NM #117 confirmed resident #022's written plan of care had not been revised to include the above recommendations. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of two CIS reports revealed the following incidents:
- On two identified dates, resident #021 demonstrated specified inappropriate responsive behaviours towards resident #020. On both incidents, resident #020 lost his/her balance and fell.

Review of resident #021's written plan of care revealed the resident had specified inappropriate responsive behaviours and interventions to manage the resident's responsive behaviours with certain residents. However, the plan of care had not specified which residents.

Interview with PSW #130 revealed that the staff member was aware the specified interventions but he/she was unable to identify those residents.

Interviews with the DON and MCI confirmed resident's #021's plan of care had not provided clear direction to staff by identifying which residents for the specified interventions. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of resident #061's RAI-MDS assessment and written care plan revealed the resident was incontinent.

Interview with PSW #103 and RPN #114 indicated that the resident would always call to be taken to the washroom. PSW #103 further stated that he/she believed the resident was continent as the resident would wait to be taken to the washroom. Interview with NM #117 and the DON confirmed the lack of collaboration in the assessment of the resident's continence level, so the assessment of the resident's continence status would be integrated, consistent with and complement each other. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review of a CIS report and the progress notes revealed on an identified date, resident #033 fell and was transferred to hospital. The fall was unwitnessed and the resident sustained a specified significant injury from the fall.

Review of resident #033's current plan of care indicated the resident was at risk for falls and had identified interventions for falls prevention.

On June 23, 2016, the inspector observed on two occasions that three interventions were not put in place for resident #033, as required by the resident's plan of care.

Interviews with PSW #120 and RPN #148 indicated the resident used to have the interventions for falls prevention. They were discontinued because the resident did not like to use them. Interviews with the PT and NM #117 indicated two interventions were discontinued on an identified date because the resident refused to use them. The PT and NM #117 further indicated the resident did not like to use the third intervention and due to the change of the resident's medical condition, it was no longer necessary and therefore

it was discontinued.

The PT, RPN #148 and NM #117 confirmed the plan of care, in relation to the interventions, was not revised when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

5. Review of a CIS report revealed resident #072 demonstrated an identified inappropriate responsive behaviours towards another resident on an identified date. The home had taken specified actions in response to resident #072's inappropriate responsive behaviours.

Review of resident #072's plan of care revealed a specified intervention to manage the resident's inappropriate responsive behaviours during the identified periods of a day. Observation on June 28, 2016, at the identified period, revealed the specified intervention was not implemented for the resident.

Interview with NM #117 revealed that the specified intervention does not need to be implemented during all the identified periods because resident #072's inappropriate responsive behaviours are more stable and not at risk of anyone. NM #117 admitted that the plan of care needed to be updated to indicate that the specified interventions should be implemented only when the inappropriate responsive behaviours were noted.

Interview with the DON confirmed resident #072's plan of care was not updated when his/her needs changed. [s. 6. (10) (b)]

6. Review of a CIS report revealed an allegation of a staff to resident neglect on an identified date. Resident #061 rang the call bell requesting a specified care. Resident rang the call bell multiple times, with the last call put on by an identified co-resident, before staff came in to provide the care. Resident #061 and the co-resident made a complaint to the registered staff regarding the incident. The home initiated an investigation and took identified actions towards PSW #101 who did not provide timely care to the resident.

Further review of the CIS report revealed that a specified intervention will be implemented for the resident to ensure safety, and the care plan will be adjusted to reflect the need of the resident. Review of the resident's written care plan dated an identified date did not reveal the revision for the specified intervention.

Interview with RPN #114 and the DON confirmed that the resident's written plan of care was not revised to reflect specified interventions. [s. 6. (10) (b)]

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 plan of care sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident,
- Staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
- The resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy in place to promote zero tolerance of abuse and neglect of residents was complied with.

Review of the home's policy #P-10 titled Abuse and Neglect Policy revised date March 10, 2016, revealed that staff are to report any suspicion of improper or incompetent treatment or care of a resident and the information upon which it is based to both the home and to the Director. The policy further states that staff must adhere to the mandatory reporting obligations set out in the LTCHA 2007.

Review of a CIS report revealed PSW #113 was observed providing improper care to resident #013 on an identified date. The incident was not reported to the Director until four days later when the DON received a written account of the events from DC #145.

Interview with DC #145 revealed he/she had witnessed the above mentioned improper care and gave a verbal account of the incident to the DS and the DSS on the same day. DC #145 then submitted a written report to the Administrator which included details of the incident via email later that day. The Administrator could not confirm when the home received this email.

Review of a signed statement and interview with the DS revealed DC #145 observed PSW #113 providing a specified care to resident #013 in a specified inappropriate manner on the identified date. The DS stated because the DSS was present during this verbal report, he/she expected him/her to follow up and report the incident.

Interview with the DSS revealed that he/she had assumed the DC had immediately informed the Administrator of the incident. The DSS admitted he/she did not follow up to ensure it had been reported. Interview with the Administrator revealed he/she could not recall ever receiving this verbal report.

Interview with the DON confirmed that in this case the part time DS, the DSS, and DC #145 all had a duty to report the incident immediately to the Director and had failed to do so. In this case, the licensee has failed to ensure that the written policy in place to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

2. Review of a CIS report submitted on an identified date revealed that PSW #149 had witnessed an alleged abuse of resident #002 on the identified date, and subsequently reported this incident nine days later to the DON.

Interview with PSW #149 revealed that he/she had been apprehensive to report and had been unaware of the reporting requirements under the Act.

Interview with the DON confirmed that the above mentioned incident of alleged abuse had not been reported immediately to the Director. [s. 20. (1)]

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 written policy in place to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.

a. Review of resident #061's written care plan dated an identified date revealed the resident to be incontinent requiring specified assistance. The resident would use the call bell to request assistance.

Review of a CIS report revealed on an identified date, the resident rang the call bell and requested assistance for care. The resident was not provided with the care by PSW #134 who responded to the call. The resident rang the call bell the second time and the care was provided by PSW #143.

Review of another CIS report revealed on another identified date, the resident rang the call bell and requested assistance with care. PSW #144 responded to the call and the specified care was not provided to the resident.

Resident #061 was not available for interview.

Interviews with PSW #134 and #144 confirmed that the resident was not provided with the specified care on the two above mentioned dates. Interview with the DON confirmed the resident was not provided with the specified care.

b. Review of a CIS report revealed an allegation of staff to resident neglect on an identified date. Resident #061 rang the call bell to request a specified care. Resident rang the call bell multiple times, with the last call put on by an identified co-resident, before staff came in to provide the care. On the same night, both residents made a complaint to the registered staff regarding the incident. The day nurse manager was notified by the night nurse the next morning. The home initiated an investigation and took identified actions towards PSW #101 who did not provide timely care to the resident.

Review of the home's investigation notes revealed PSW #101 went in to the resident's room to respond to the first call, however did not assist the resident with the specified care. PSW #101 stated he/she received the permission from the resident to go on break and will provide the specified care upon return. However the resident rang the call bell again while PSW #101 was on break. PSW #102 was covering for PSW #101 while he/she was on break. PSW #102 and a third PSW #167 did not respond to the resident's call bell. After an identified period of time, PSW #101 returned from break and went into the resident's room to provide the specified care for the resident.

The inspector interviewed resident #062 as resident #061 was not available for interview. Resident #062 indicated that the specified care was not provided to resident #061 until an identified period of time after the call bell was rung.

Interviews with PSW #101 confirmed that the specified care was not provided to the resident the first time he/she called for assistance. Interview with PSW #102 confirmed that the PSWs covering for break did not respond to the call bell and provide specified care to the resident as requested. Interview with the DON confirmed that the resident's specified care need was neglected by PSW #102 and #167. [s. 51. (2) (c)]

2. Review of a CIS report submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed that on an identified date, resident #001 had called at an identified time for a specified care. The CIS report further revealed that PSW #153 responded to the call bell rung by resident #001 informing the resident that he/she was going on break and could not provide the specified care to him/her at that time.

Review of the most recent written plan of care revealed that resident #001 required staff assistance for the specified care.

Interview with PSW #153 revealed he/she had told the resident that they were going on break and was unable to provide the specified care to him/her. PSW #153 further revealed that he/she had endorsed to oncoming staff that resident #001 had requested the care.

Interview with PSW #110 revealed that at an identified time, he/she answered a call bell rung by resident #001. Resident #001 revealed to PSW #110 that he/she had been waiting for assistance with the specified care. PSW #110 further revealed that he/she had not been aware that resident #001 required the care until he/she answered the call bell.

Interview with the DON confirmed PSW #153 had neglected and had not provided resident #001 with the assistance required. [s. 51. (2) (c)]

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 resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Review of a CIS report revealed DC #145 observed resident #013 was being fed using improper techniques and safe positioning by PSW #113, and the resident was in distress.

Record review revealed resident #013 had identified medical diagnoses. Resident #013's plan of care stated he/she required identified interventions for eating.

Interview with DC #145 revealed that on an identified date, PSW #113 had been feeding resident #013 using improper techniques.

Review of an identified home's document revealed PSW #113 was disciplined for the above mentioned incident.

Interview with PSW #113 revealed that he/she had been feeding resident #013 and had fed the resident using improper techniques. The PSW acknowledged what the proper techniques should be for feeding residents.

Interview with the DON confirmed that the licensee failed to ensure that PSW #113 had used proper techniques to assist resident #013 with eating, including safe positioning of a resident who required assistance. [s. 73. (1) 10.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring the staff member.

Record review of staff personnel files revealed that PSW #150 had been hired on an identified date. PSW #150's personnel file revealed that a criminal reference check had been completed on another identified date, but it was incomplete as a vulnerable sector screening had not been conducted.

Interview with Administrator #116 confirmed that a vulnerable screening had not been conducted with the criminal reference check prior to PSW #150's hire date. [s. 75. (2)]

WN #7: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Record review of a CIS report and the progress notes revealed on an identified date, resident #032 fell and sustained an identified significant injury. The fall was unwitnessed, and the resident was transferred to hospital on the same day and received a specified treatment. The incident was reported to the Director three business days later.

Interview with the DON indicated the incident was reported by the former DON and confirmed it was not reported to the Director until three business days after the occurrence of the incident. [s. 107. (3) 4.]

2. Record review of a CIS report and the progress notes revealed on an identified date, resident #033 was found lying on the floor with a specified significant injury. The resident was transferred to hospital on the same day and diagnosed with an identified medical

condition. The fall was unwitnessed and the resident returned to the home seven days later. Further review of the CIS report indicated the incident was reported to the Director three business days after the occurrence of the incident.

Interview with the DON indicated the incident was reported by the former DON and confirmed it was not reported to the Director until three business days after the occurrence of the incident. [s. 107. (3) 4.]

3. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
- A description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.
- Actions taken in response to the incident, including, for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and the outcome or current status of the individual or individuals who were involved in the incident.
- Analysis and follow-up action, including the immediate actions that have been taken to prevent recurrence.

Review of a CIS report submitted on an identified date in 2015 revealed that six days after the report was submitted, an amendment had been requested with the following information to be included in the report:
- identify the accused staff member in the description of the incident,
- include if the staff member has a history of discipline,
- family member's response when notified of the incident and,
- the outcome of the home's investigation.

Interview with DON confirmed that the above mentioned CIS report had not been amended as per the request of the Director. [s. 107. (4)]

4. Review of a CIS report submitted on an identified date revealed RN #125 observed resident #052 demonstrated inappropriate responsive behaviours towards resident #053. Two days after the submission, the Central Intake Assessment and Triage team (CIATT) requested an amendment of the report to include the identified areas for the resident's responsive behaviours.

Review of the progress notes revealed an identified incident for resident #052's responsive behaviours.

Review of an interdisciplinary care team meeting progress note made on an identified date indicated specified interventions to manage resident #052's responsive behaviours.

Interview with the Administrator and DON confirmed the CIS had not been amended to include any history of responsive behaviours, the current status of resident #052 and specific interventions to prevent recurrence of such incidents. [s. 107. (4)]

Issued on this 13th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MATTHEW CHIU (565), ADAM DICKEY (643), ANGIE KING (644), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), SUSAN SEMEREDY (501), TILDA HUI (512)
Inspection No. / No de l'inspection :	2016_334565_0009
Log No. / Registre no:	018980-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 1, 2017
Licensee / Titulaire de permis :	INA GRAFTON GAGE HOME OF TORONTO 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
LTC Home / Foyer de SLD :	INA GRAFTON GAGE HOME 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rob Bissonnette

To INA GRAFTON GAGE HOME OF TORONTO, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents, are protected from abuse by anyone and to ensure that all residents are not neglected by the licensee or staff.

The plan shall include, but not limited to the following:
1. Mandatory re-education for all staff on the home's Abuse and Neglect policy, to include:
a. Policy to promote zero tolerance of abuse and neglect of residents,
b. Clearly set out what constitutes abuse and neglect,
c. Relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care,
d. Situations that may lead to abuse and neglect and how to avoid such situations,
e. Analysis of every incident of abuse or neglect of a resident at the home
2. Evaluate the education in #1 to ensure it is effective in providing quality and safe care to all residents, and implement quality management systems for monitoring / auditing compliance with the home's Abuse and Neglect, policies and procedures.

The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to matthew.chiu@ontario.ca by February 24, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Review of a Critical Incident System (CIS) report revealed an allegation of staff to resident abuse was reported on an identified date. Resident #061 rang the call bell requesting a specified care. PSW #144 responded to the call and went into the resident's room together with an identified PSW. According to the resident's roommate, resident #062, he/she heard PSW #144 responded to resident #061 in a manner that made the resident upset and heard a slapping sound. Resident #062 intervened and both PSWs left the room. As PSW #144 passed by resident #062's bed when leaving the room, resident #062 heard an inappropriate verbal comment from PSW #144 towards resident #062.

On the same day, both residents reported the incident to PSW #103. PSW #103 involved the day charge nurse who then in turn notified the DON. Both residents were interviewed by the DON and both stated they were very upset with the action of PSW #144. The home had completed an investigation and taken identified actions to both PSWs.

The inspector interviewed resident #061's roommate as resident #061 was unavailable for interview. Resident #062 confirmed that PSW #144 did yell at resident #061 and did not provide the specified care to resident #061 as requested. Resident #062 did not witness any inappropriate physical force was applied towards resident #061. During the interview, resident #062 confirmed that PSW #144 had made the inappropriate verbal comment towards him/her while on his/her way out of the room.

Interview with PSW #144 indicated that resident #061 was not provided with the specified care as requested when PSW #144 went into the resident's room to respond to the call bell. However, PSW #144 denied the other above mentioned allegations towards residents #061 and #062.

Several attempts were made but failed to interview the identified RPN and the identified PSW on duty on the unit when the alleged abuse/neglect took place.

Interview with the DON confirmed PSW #144 had neglected to provide care to resident #061 to meet the resident's specified care needs. Based on the evidence provided by resident #062, the DON confirmed the finding of abuse to residents #061 and #062 by PSW #144.
(512)

2. Review of a CIS report revealed an allegation of staff to resident neglect was reported on an identified date. Resident #061 was left unattended in the washroom for an extended period of time.

Review of resident #061's care plan revealed the resident had physical impairments and required specified assistance for ambulation and toileting for safety.

Resident #061 was unavailable for interview, and the inspector interviewed resident #062 who was resident #061's roommate. Resident #062 recalled the above mentioned incident and he/she could not recall how long resident #061 stayed in the washroom.

The inspector interviewed PSW #143 who stated that he/she did toilet resident #061 on the identified date. The PSW recalled toileting resident #061 and waited outside the washroom door until the resident was ready to be transferred, about five minutes later. According to PSW #143, he/she received assistance from RPN #126 who was in the same room providing care to the resident's roommate. The inspector interviewed RPN #126 who insisted that resident #061 was provided continence care in bed. The inspector interviewed staff #167 who provided information on the PSW flow sheet on Point-of-Care (POC) to indicate that resident #061 was toileted on the identified date at an identified time.

Based on the statement provided by PSW #143 that he/she did toilet resident #061, supported by the POC documentation, and the time that the resident was found still in the washroom, there is evidence to indicate resident #061 was left in the washroom for the identified period of time.

Interview with the DON confirmed resident #061 was left on the toilet on the identified date, and that PSW #143 had neglected to assist the resident back to bed before he/she finished his/her shift duty.

(512)

3. Review of a CIS report revealed PSW #121 identified a specified altered skin integrity on resident #046 and reported it to the nurse in charge.

During the home's investigation, the resident had stated an identified sharp

object could have caught the skin that resulted in the specified altered skin integrity. The resident had also indicated that the staff had been rough when they provide care to him/her. Staff searched for the identified sharp object and found none. The resident was given support and re-assurance that staff will be gentler when they provide care to him/her.

Review of resident #046's written plan of care revealed the resident had specified medical conditions and required assistance for activities of daily living (ADLs) due to pain in certain specified areas.

Interview with the resident confirmed he/she had pain and it had been painful when the staff provided care as they had been too rough during assistance with an identified ADL.

Interview with PSW #121 confirmed the resident had always complained of pain when they provided care. Further the PSW confirmed he/she knew the resident had received pain medication some time during the day. The staff member also confirmed he/she had not communicated to the nurse in charge about the daily complaints of pain because as the PSW went to tell the nurse, the resident stated he/she had no pain.

Interview with the NM confirmed the resident had been complaining of PSW #121 being rough while providing personal care and the home had taken specified action to the staff. Further the NM confirmed the staff is expected to be gentle when providing care to the residents and to consider the resident's health condition and should have reported to the nurse that the resident was still complaining of pain despite receiving analgesics. PSW #121 neglected resident #046 when the PSW failed to acknowledge the resident's complaints of pain and not reporting the complaints to the registered staff.
(600)

4. Review of a CIS report revealed on an identified date, resident #042 had reported PSW #118 to the licensee because the PSW made some specified inappropriate verbal comments to the resident during an identified ADL and that made the resident very upset.

Interview with resident #042 confirmed on the identified date, the resident wished PSW #118 to provide a specified care during the identified ADL. The PSW had ignored resident's request and made the inappropriate verbal

comments to the resident.

Interview with PSW #118 confirmed he/she assisted resident #042 during the identified ADL on the identified date. The resident became upset because the PSW refused to provide the specified care.

Further, the PSW confirmed that he/she made a statement to the resident in order to calm him/her down. Although the PSW found no bad meaning in his/her statement, the resident became upset about the statement. The PSW acknowledged that he/she would not use the same approach for any other resident however he/she did not go back to clarify with the resident what made the resident upset about PSW's statement.

Interview with the DON revealed the resident might have not heard what the PSW had said exactly. After the DON heard the PSW statement from the interview with the inspector, the DON confirmed that it was not the way staff should have spoken to the resident and PSW #118's approach was not appropriate. (600)

5. Review of a CIS report revealed on an identified date, resident #041 was noted with a specified injury. The resident had not been able to explain how he/she sustained the injury. The resident was discharged from the home on an identified date, about one month later.

Review of a Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment indicated resident #041 needed a specified number of staff assistance for transfer. Review of the resident's written plan of care revealed the resident needed the specified number of staff with a specified level of assistance for transfer due to his/her specified medical condition. Review of the PSW's documentation sheet for an identified month revealed the resident had used the specified assistance. However the record failed to reveal as to what level of assistance have been provided to the resident and how many staff were involved during the transfer on the day before staff had noted resident #041's specified injury.

Interview with PSW #108 revealed on the day before staff had noted resident #041's specified injury, he/she had transferred the resident alone instead of the specified number of staff required. Further the PSW confirmed he/she had been transferring the resident alone each time he/she had been assisting the resident.

The staff member also revealed he/she had not considered the fact that the other PSWs had been providing the specified transfer assistance to the resident. PSW #108 confirmed he/she was aware of the resident's specified medical needs for transfer, but he/she used own techniques when transferring the resident.

Interview with the DON confirmed PSW #108 neglected resident #041 when the PSW failed to provide the resident the assistance required for safe transferring.

The severity of the non-compliance and the severity of the harm is actual.

The scope of the non-compliance is isolated to residents #041, #042, #046, #061 and #062.

A review of the Compliance History for the last three years revealed no non-compliances related to the Long-Term Care Homes Act, 2007, s. 19. (1). (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Matthew Chiu

Service Area Office /
Bureau régional de services : Toronto Service Area Office