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
Aug 29, 2019	2019_767643_0025	027207-18, 000275-19, 012882-19, 014545-19, 014943-19	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

ADAM DICKEY (643)

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 8, 9, 13-16, and 19, 2019.

The following complaint intakes were inspected during this inspection:
Log #027207-18 and Log #000275-19 - related to recreation and social activities;
Log #014545-19 - related to cooling requirements;
Log #012882-19 - related to alleged staff to resident abuse; and
Log #014943-19 - related to alleged neglect, residents' rights and maintenance services.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (ED), the Director of Care (DOC), Environmental Services Manager (ESM), Programs Manager, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Maintenance Services Lead, Personal Support Workers (PSW), Dietary Aides (DA), Program Therapists, residents and family members.

During the course of the inspection, the inspector(s) conducted observations of staff to resident interactions and the provision of care, record review of resident health records, the home's internal investigation notes, relevant policies and procedures, staff training materials and training attendance documentation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006’s right to be treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity was fully respected and promoted.

Two separate anonymous complaints were submitted to the Ministry of Long-Term Care (MLTC) regarding alleged staff abuse of resident #006. Anonymous complainant #201 indicated that resident #006 was being verbally abused by PSW #105 and RN #106 was not doing anything to address it. Complainant #201 indicated that resident #006 was called identified derogatory names about their physical appearance in a specified resident home area by PSW #105. Anonymous complainant #202 indicated that there had been concerns about staff of the home making comments about resident #006's physical appearance which had been previously investigated and reported by the home to the Director.

Review of a Critical Incident System (CIS) report submitted by the home on an identified date, indicated that resident #006 had reported to the home that a PSW that had been caring for them made comments regarding their physical appearance during care. Review of the home’s investigation notes related to this CIS showed that PSW #105 indicated to the DOC on the above identified date, that they had made identified comments to resident #006 regarding their physical appearance and condition. Further review of the investigation notes showed that PSW #105 was counseled not to make the above identified comments to resident #006, and resident #006 was satisfied as long as the comments stopped.

In an interview, resident #006 indicated that PSW #105 had made comments about their physical appearance in the past, but did not recall the specific comments that were made. Resident #006 indicated that they tried to not let the comments bother them, but felt that PSW #105 had no reason to talk about them like they did. Resident #006

indicated that they had a different PSW assigned to their care and was happier with that PSW's treatment of them.

In an interview, PSW #105 indicated that they had used a specified term referring to resident #006's physical condition when providing care to the resident. PSW #105 indicated that resident #006 would want them to help the resident with specified care assistance, and PSW #105 would tell the resident they needed another staff member because of their physical condition.

In an interview, RN #106 indicated that resident #006 would repeatedly use the call bell and be demanding of staff to do things right away. RN #106 indicated that as a result of these frequent requests they and PSW #105 had told the resident that they would have to wait for another staff member because of the above mentioned physical condition.

In an interview, the DOC indicated that they had submitted the above mentioned CIS report, and investigated the allegations with staff on the unit. The DOC indicated that investigation found the staff did not call the resident a specified derogatory name regarding their physical appearance, and only used a specified term to refer to their physical condition. The DOC indicated that they did not believe that PSW #105 and RN #106 used the term in a demeaning way, but understood that resident #006 might have been affected by the comments. [s. 3. (1) 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 resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather illness prevention and management plan for the home was implemented when required to address the adverse effects on residents related to heat.

A complaint was submitted to the MLTC on an identified date, which indicated that on a specified date four days earlier, the complainant visited the home and the temperature was hot, and though the home had central air conditioning (A/C) they believed it was not running. The complainant indicated that their family member, resident #004, appeared uncomfortable. The complaint indicated that no manager was on site to deal with the issue and had filed a complaint with the home.

Review of the home’s policy titled Hot Weather Related Illness, policy #G-20, revised May 3, 2019, showed that where the humidex in the home cannot be maintained below 29 degrees Celsius (C) appropriate care for residents through evidence based practices and implementation of hot weather related plans. The policy further indicates that the Nurse Manager/ Environmental Services Manager or delegate are to assess indoor temperatures and humidex levels at 1100 and 1600 hours daily in resident home areas and use humidex tables and measurement strategies, and report humidex readings of 29 degrees C or higher. The policy indicates protocols are to be put into place as soon as the humidex reading is 29 degrees C or higher.

Review of a written complaint submitted to the home via electronic mail (e-mail) from resident #004’s family member indicated that their resident room was hot, resident #004 appeared uncomfortable and that the nurse on the unit was asked to assess the resident. The complaint indicated that resident #004 had consumed a large volume of fluids at mealtime. The complainant indicated that they believed there was an issue with the fresh air intake, and potentially the system itself. In response to the written complaint from

resident #004's family member the home's ESM responded in writing indicating that there was a lack of communication and that the increased temperature in the home was never reported to the Manager on-call and that the central air conditioning was on, with open windows nullifying the effect of the A/C.

Review of the home's room temperature log from the identified date of the concern, showed that on an identified resident home area a temperature and humidity reading had been obtained on day shift in a specified resident room. The log showed the temperature was recorded to be 24 degrees C with humidity recorded as 68 per-cent. The humidex was documented as 29 degrees C. The log further showed that for the evening shift temperature and humidity were recorded again in the same resident room specified above. The log showed that the temperature was recorded as 25 degrees C and humidity was recorded as 63 per-cent. Humidex for the evening shift in the specified room was recorded as 31 degrees C. The temperature logs from the other resident home areas were also reviewed, with a second identified resident home area's day shift temperature in a specified resident room was recorded as 31 degrees C with humidity recorded as 45 per-cent. The log for the second identified resident home area showed the humidex was recorded on the day shift as 35 degrees C. The second resident home area's log showed that for the evening shift the temperature was recorded in the specified resident room as 29 degrees C, humidity was recorded as 30 per-cent and humidex recorded as 30 degrees C.

In an interview, the home's ESM indicated that it was the expectation of the home for registered staff on each unit to record the temperature in the room specified in the temperature log. The registered staff were then expected to record the humidity in the log and use the Humidex scale to determine the humidex in the area specified on the log. The ESM indicated that when the humidex was assessed to be at 29 degrees C or above, it was the expectation for the registered staff to call maintenance staff in the home to investigate and attempt to address the problem. The ESM indicated that if the humidex could not be maintained at below 29 degrees C after maintenance staff intervention the home's management should be notified in order to notify all units that the home's hot weather protocol should be followed. The ESM indicated that no call was initiated to maintenance staff or themselves indicating that the humidex had been assessed on the two above mentioned identified resident home areas as 29 degrees C or greater.

In an interview, the ED indicated that it was the process in the home for registered staff on each unit to measure and record the temperature and humidity and assess the humidex level using the scale available on each unit. The ED indicated that when a

humidex level was assessed at 29 degrees C or greater the registered staff member should contact maintenance staff on-site to troubleshoot first, then contact the management in the home or designated manager on-call on weekends to notify them of the humidex level and communicate to all units to implement the home's hot weather protocol. The ED acknowledged that on the above identified date, the two above identified resident home areas had recorded humidex levels of 29 degrees C or higher and neither maintenance nor manager on-call were contacted. The ED acknowledged that the registered staff did not implement the written hot weather illness prevention and management plan as the Manager on-call was not contacted. [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 a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

Issued on this 29th day of August, 2019

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

Original report signed by the inspector.