Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2021	2021_650565_0011	015698-20, 024424-20, 001355-21	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

MATTHEW CHIU (565)

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): June 1-3, 8-11, and 14-18, 2021.

The following intakes were completed in this complaint inspection:
Log #001355-21 and Log #015698-20 were related to prevention of abuse and neglect; and
Log #024424-20 was related to multiple care concerns.

During the course of the inspection, the inspector(s) spoke with the interim Executive Director (ED), Director of Care (DOC), Infection Control Manager (ICM), Manager of Clinical Informatics (MCI), Clinical Practice Coordinator (CPC), Nurse Managers (NMs), Environmental Services Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Personal Support Workers (PSWs), Housekeeping staff, Residents, and Family Members.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

Inspector, April Chan (#704759) attended this inspection during orientation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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 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 used safe positioning techniques when assisting resident #005.

Resident #005 had both cognitive and physical impairments and required assistance for transferring and positioning in their wheelchair. The resident had a fall and sustained an injury. Prior to the fall, staff transferred the resident onto their wheelchair, and positioned them in an unsafe manner that increased their risk for fall and skin breakdown.

Source: Resident #005's clinical records; interviews with the RN, CPC and other staff. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was assisted with getting dressed as required and was dressed appropriately.

Resident #004 had both physical and cognitive impairments and required staff assistance for getting dressed. A family member of resident #004 found the resident dressed inappropriately in their room and complained to the nurse on the unit. The unit nurse and PSW responded, adjusted the resident's clothing, and admitted the resident's clothing was not worn appropriately.

Source: Resident #004's clinical records; interviews with family member, the RPN and other staff. [s. 40.]

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 each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for complaints made to the licensee or a staff member concerning the care of residents #005 and #006, a documented record was kept in the home that includes,
(a) The nature of each verbal or written complaint;
(b) The date the complaint was received;
(c) The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) The final resolution, if any;
(e) Every date on which any response was provided to the complainant and a description of the response; and
(f) Any response made in turn by the complainant.

a. Resident #005's family member emailed the former DOC to complain the care concerns related to the resident. The next day, the family member received a response indicating the home was looking into it. About three weeks later, the family member reached out to the ED regarding the care concerns and not receiving a follow up response for their complaint.

The home used a client service response (CSR) form to document records of a complaint. The home did not have documented records related to the date the complaint was lodged, every response that the home provided to the complainant, and any response made in turn by the complainant prior to the ED being contacted.

b. Resident #006's family member complained to the home regarding a missing item. The family member stated the home did not resolve their complaint to their satisfaction.

The home initiated a CSR and started an investigation on the same day. The CSR stated the nature of the complaint included suspicions of theft and the last documented record, dated five days later, stated that they contacted the complainant.

There were no documented records kept in the home related to any other response that was provided to the complainant after the last documented record, and any response made in turn by the complainant on or after the last documented record. There were no documented records indicating if any final resolution was made.

c. Resident #006’s family member spoke with the former nurse manager regarding the concern of another missing item. The family member stated that the home removed the item from the resident prior to a hospital transfer, and it was found missing.

The former nurse manager documented in the progress notes on the same day that the family member notified them that someone was coming to pick up the item. The home investigated and looked into the resident’s hospital transfer record, and concluded no evidence indicating the item was removed from the resident and kept by the home. They left a voice message to the complainant and had no call back at that time.

About a week later, another family member lodged another complaint regarding another missing item. Record indicated the above-mentioned missing item was still a concern from their family.

The home did not have documented records related to the first complaint indicating the nature and the date of receipt, every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Sources: Home’s complaint records; resident #005’s family email records; resident #006’s clinical records; interviews with family members and the interim ED. [s. 101. (2)]

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 ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #4: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident #005's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #005 had both cognitive and physical impairments and they were injured due to an incident. The resident's SDM was notified of the incident and injury on the same day. The next day, staff noticed a change in the resident's injury and started a treatment without notifying the resident's SDM until about a week later.

Sources: Resident #005's clinical records; interviews with the SDM, RPN, MCI, and CPC. [s. 6. (5)]

2. The licensee has failed to ensure that resident #004's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #004 had both physical and cognitive impairments, and they required staff assistance for their care. After the resident's custom devices were found missing, an intervention was created in the resident's plan of care specifying the location that they were to be stored. When the resident received their new custom devices, staff had been storing them in another specified location, and this was to ensure that they would not be lost again. The resident's plan of care related to the storage of the devices was not revised as required.

Source: Resident #004's clinical records; interviews with the PSW, RPN, and MCI. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of resident #006 has occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director.

A complaint was brought to the home by resident #006's family member regarding a missing item. The home initiated a CSR and started an investigation on the same day. The CSR stated the nature of the complaint included suspicions of theft, and they contacted the police two days later. The incident was not reported to the Director until five days after the suspicions of theft.

Sources: CIS report #C609-000003-19; home's complaint and investigation records; interviews with family member and the interim ED. [s. 24. (1)]

Issued on this 2nd day of July, 2021

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

Original report signed by the inspector.