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

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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
Dec 23, 2021	2021_891649_0022	011045-21, 011444-21, 012010-21, 017528-21	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

JULIEANN HING (649), STEPHANIE LUCIANI (707428), WING-YEE SUN (708239)

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): November 18, 19, 22, 23, 24, 25, 26, 29, December 1, 2, and off-site on November 30 and December 15, 2021.

The following Critical Incident System (CIS) intakes were completed during this CIS inspection:
Log #011045-21, CIS #3034-000010-21 related to plan of care,
Log #011444-21, CIS #3034-000011-21 related to continence care and bowel management, and
Logs #012010-21, CIS #3034-000012-21 and #017528-21, CIS #3034-000014-21 related falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC)/Nurse Consultant, Nurse Manager (NM), Infection Control Manager (ICM), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping, Coronavirus COVID-19 Screener, and residents.

During the course of the inspection the inspectors observed staff to resident interactions, reviewed residents' clinical records, staffing schedules and observed infection prevention and control (IPAC) practices.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

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

- **3 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. 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents who were incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

According to the resident's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment they had a change in continence status from usually continent to frequently incontinent. Staff interviews indicated that registered staff were expected to complete a continence assessment however, no continence assessment was completed for the resident when they became frequently incontinent.

Two Personal Support Workers (PSWs) acknowledged that the resident was incontinent. The Registered Practical Nurse (RPN) indicated the resident's continence status changed from usually continent to frequently incontinent and confirmed that a continence assessment was not completed.

The Registered Nurse (RN) and Acting Director of Care (DOC) both acknowledged that a continence assessment should have been completed for the resident when they experienced a change in continence status.

Sources: review of resident's clinical records, interviews with RPN, RN and Acting DOC.

[s. 51. (2) (a)]

2. As a result of non-compliance identified for the above resident the sample was expanded to another resident.

According to resident's RAI-MDS assessment, they had a change in continence status from occasionally incontinent to frequently incontinent. Staff interviews indicated that registered staff were expected to complete a continence assessment however, no continence assessment was completed when the resident's continence status changed.

The PSW indicated that the resident was incontinent.

The RPN acknowledged the resident's continence status changed from occasionally incontinent to frequently incontinent and confirmed that a continence assessment was not completed.

The Acting DOC acknowledged that a continence assessment should have been completed for the resident when they experienced a change in continence status.

Sources: review of resident's clinical records, interviews with RPN, and Acting DOC. [s. 51. (2) (a)]

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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #2: 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. (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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a description of the individuals involved in three incidents including names of any staff members or other persons who were present at or discovered the incidents were identified in the critical incident reports submitted by the home for three residents falls.

A CIS report submitted to the MLTC indicated that a resident had a fall that resulted in an injury. The name of the staff who witnessed the resident's fall was not included in the CIS report.

The PSW who was present at the incident was not identified in the critical incident report submitted by the home for the resident's fall resulting in injury.

The PSW acknowledged being present when the resident fell and told the inspector that they had removed the cart out of the resident's reach and tried to redirect the resident to another area. The resident had a responsive behavior, lost their balance and fell.

Acting DOC acknowledged the PSW's name was not included in the CIS report.

Sources: CIS report, resident's progress notes, and interviews with PSW and Acting DOC. [s. 107. (4) 2.]

2. As a result of non-compliance identified for the above resident, the sample was expanded to another resident.

A CIS report submitted to the MLTC, indicated that a resident had a fall resulting in injury and was transferred to hospital.

Review of the CIS report indicated that the names of the staff who discovered resident's fall were not identified.

Two PSWs acknowledged that they discovered resident's fall. Acting DOC acknowledged the two PSWs who discovered the resident's fall, should have been identified on the CIS report.

Sources: CIS report, resident's progress notes, and interviews with PSWs and Acting DOC. [s. 107. (4) 2.]

3. As a result of non-compliance identified for the above two residents, the sample was expanded to another resident.

A CIS report submitted to the MLTC indicated that the resident had an unwitnessed fall that resulted in an injury. The name of the staff who discovered the resident's fall was not included in the CIS report.

The RPN acknowledged that it was a PSW who discovered the resident on the floor and alerted the RPN of the unwitnessed fall. The Acting DOC acknowledged that the PSW who discovered the resident was not included in the CIS report.

Sources: CIS report, resident's progress notes, and interviews with RPN and Acting DOC. [s. 107. (4) 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 to ensure the Director is informed of the names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the home's infection prevention and control program.

Several observations were made by Inspector #649 related to the home's practice of hand hygiene under the infection prevention and control program (IPAC).

(i) Observation of Warden Woods home area morning snack pass by Inspector #649 showed:
-The PSW went into a resident's room to serve snack and did not perform hand hygiene before contact with the resident's environment, despite a contact precaution sign posted on the resident's door. The PSW touched the resident and failed to perform hand hygiene after they came into contact with the resident. The PSW then returned to the snack cart and handled the snacks without performing hand hygiene.
-The PSW served eight resident snacks in the TV room without performing hand hygiene in between serving residents.
-The PSW went into three resident rooms and failed to perform hand hygiene before coming into contact with the residents' environment.
-The PSW did not assist any of the residents with hand hygiene before serving them their snack, and a hand sanitizer was not observed on the snack cart during the snack pass.

(ii) As a result of non-compliance identified on Warden Woods home area another snack observation was completed on the Rouge Valley home area in the afternoon on November 18, 2021, by Inspector #649 which showed:
-The PSW served six resident snacks who were in the dining room and failed to perform hand hygiene in between contact with the residents.
-The PSW served a resident their snack and touched one of the resident's personal items, then proceeded to serve another resident their snack without performing hand hygiene in between contact with the residents and the snack cart.

-The PSW served seven resident snacks in the TV room and failed to perform hand hygiene in between residents.
-The PSW served another five resident snacks and failed to perform hand hygiene in between residents. They then they proceeded to assist a resident with feeding and failed to perform hand hygiene before and after doing so.
-Hand sanitizer was noted on the snack cart but the PSW failed to use it during the above mentioned observation. They did not assist any of the residents with hand hygiene before serving them their snack.

(iii) An additional snack observation was completed on Golden Mile home area on the morning of November 19, 2021, by Inspector #649 which showed:
-The PSW served seven resident snacks and failed to perform hand hygiene in between residents. Then they took two empty cups from two different residents and failed to perform hand hygiene.
-The PSW served two resident snacks in their room and failed to perform hand hygiene before coming into contact with the residents' environment. The PSW removed a cup from one of the resident's rooms and did not perform hand hygiene.
-The PSW did not assist any of the residents with hand hygiene before serving them their snack, and hand sanitizer was not observed on the snack cart.

The home's Hand Hygiene policy directed staff to follow the Four Moments of Hand Hygiene and clean their hands before contact with the resident's environment and before touching a resident.

The above mentioned observations were brought to the Infection Control Manager's (ICM) attention who acknowledged that staff should follow the four moments of hand hygiene.

Acting DOC acknowledged that staff should clean their hand in between giving snacks to residents and in between removing soiled items. This practice put residents at risk of transmission of infectious disease.

Sources: Observations of snack passes on November 18 and 19, 2021, review of home's hand hygiene policy # IFC H-15, last revised on December 18, 2020, interviews with PSWs and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 5th day of January, 2022

[redacted]

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

Original report signed by the inspector.