Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2012	2012_021111_0029	O-001271-12	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

LYNDA BROWN (111)

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): October 9 & 10, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator and the Director of care (DOC).

During the course of the inspection, the inspector(s) observed toileting of current residents on one floor, reviewed the health record for a deceased resident, and reviewed the homes policy on Falls Prevention Management.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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 :

Review of health record for resident #1 indicated:
-The resident had a history of infections and altered bladder function
-The resident sustained two falls resulting in pain and injury while being assisted by staff.The staff were to assist the resident with a mobility device and there was no indication the device was used or that the staff revised the plan of care when the level of care required for mobility was ineffective. -The resident was also to have a physician ordered treatment and there was no indication the treatment occurred.

1. The licensee failed to ensure that the written plan of care for resident #1 indicated the plan of care related to bladder function [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for resident #1 that provided clear direction to staff and others who provided care to the resident related to alteration in bladder function and infections. [s. 6. (1) (c)]

3.The licensee failed to ensure that the care set out in the plan of care for resident #1 was provided to the resident related to physician ordered treatments. [s. 6.(7)]

4.The licensee failed to ensure the that the plan of care for resident #1 was reviewed and revised when the care needs changed, when the care set out in the plan was no longer necessary and when the care set out in the plan was in-effective related to falls and mobility. [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 all current residents have a written plan of care that provides the planned care for the resident, provides clear direction to staff and others who provide direct care to the resident, that the care is based on an assessment of the resident, that the resident receives the care as set out in the plan and when the residents care needs change or is no longer necessary, the plan of care is reviewed and revised related to continence, infections and mobility, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Review of progress notes for resident #1 indicated the resident sustained two falls resulting in injury and pain.There was no documented evidence that any post-fall assessment was conducted using a clinically appropriate assessment instrument.

2. The licensee failed to ensure that when resident#1 had fallen, the resident was assessed post-fall using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (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 that when a resident has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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. Review of progress notes for resident #1 indicated the resident sustained two falls resulting in injury and pain while being assisted by one staff.The plan of care also indicated that staff were to use a positioning device.

2.The licensee failed to ensure that staff used positioning devices and safe transferring techniques when assisting resident #1. [s. 36.]

Issued on this 28th day of November, 2012

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

Lynda Brown