Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: January 21, 2025

Inspection Number: 2025-1528-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Ina Grafton Gage Home of Toronto

Long Term Care Home and City: Ina Grafton Gage Home, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8-10, 13-17, 20 and 21, 2025

The following complaint intakes were inspected:

- Intake: #00126917 was related to neglect, and care related concerns.
- Intake: #00132104 was related to alleged abuse.
- Intake: #00135590 was related to alleged abuse and concerns with Infection Prevention and Control practices.

The following Follow-up intakes were inspected:

- Intake: #00129393 was related to CO #001 from inspection #2024-1528-0002.
- Intake: #00129394 was related to CO #002 from inspection #2024-1528-0002

The following Critical Incident (CI) intakes was inspected:

- Intake: #00134272/ CI #3034-000041-24 was related to disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1528-0002 related to O. Reg. 246/22, s. 40

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1528-0002 related to FLTCA, 2021, s. 25 (1)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that repositioning of a resident was documented as set out in the plan of care.

The plan of care indicated that the resident was to be repositioned every certain time period related to altered skin integrity. There was incomplete documentation for two shifts over a three-month period.

Sources: Resident's Treatment Assessment Record (TAR) and an interview with staff.

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee has failed to comply with the home's zero tolerance policy on abuse and neglect when a Personal Support Worker (PSW) raised concerns about a suspected abuse of a resident by another PSW. Nurse Manager (NM) failed to report these concerns to the acting Director of Care (DOC) or the Executive Director (ED), thereby failing to comply with policy.

Sources: Resident's clinical records, the home's Abuse and Neglect Policy, and interviews with the staff.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2024-1528-0002 served on October 15, 2024, with a compliance due date of December 12, 2024.

Step 2 of CO #001 indicated the home must audit at least one investigation conducted by the DOC. The home was unable to demonstrate that the DOC conducted or was involved with any of the interviews, documentation or execution of the investigation. Therefore, the home did not comply with this component of CO #001.

Sources: CO #001 from #2024-1528-0002, the home's investigation notes for Critical Incidents (CI), an audit of the investigation of CI and interviews with the DOC and other staff.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the

Act.

Compliance History:
No previous history for s. 104 (4)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that a resident's symptoms were documented during the night shifts on two days, when the resident, who had respiratory symptoms, was placed on droplet contact precautions.

Sources: Review of resident's clinical records, interview with the Infection Prevention and Control (IPAC) Lead.

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PRACTICES

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The IPAC lead or designate to review the contents of this compliance order with all PSWs and registered staff in the home.
2. The IPAC lead or designate to re-train all PSWs and registered staff in the home, including agency staff, on hand hygiene, including the four moments of hand hygiene and assisting residents with hand hygiene prior to meals and snacks.
3. Maintain a written record of reviews and training provided to all staff that includes who attended the training, the content, and the date training was completed.

4. The IPAC lead or designate will conduct mealtime audits once daily to ensure that staff are reminding and/or assisting all residents with completion of appropriate hand hygiene. The audits must include, at minimum, one audit of each resident home area dining room per week.
5. The IPAC lead or designate will complete audits of PSW and registered staff adhere to the four moments of hand hygiene during mealtime each day. The audits must include, at minimum, one audit of each resident home area dining room per week.
6. The date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented. The audits are to be completed for a minimum of one month or until such time as there is consistent compliance.

Grounds

The licensee failed to ensure that residents were provided with or supported in performing hand hygiene prior to meals and did not implement the standard or protocol issued by the Director regarding IPAC and hand hygiene at the required moments.

Rationale and Summary:
(i) According to 10.2 (c) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to provide residents with assistance to perform hand hygiene before meals and snacks.

Observations in the dining rooms across multiple floors showed that staff failed to assist several residents with hand hygiene before meals.

PSWs, along with RPN, confirmed that they did not assist the residents with hand hygiene prior to their meals. A PSW explained that some residents may have been overlooked due to arriving late in the dining room.

The IPAC Lead confirmed that staff were required to assist all residents with hand hygiene and that best practice is to do so as soon as they arrive in the dining room.

There was an increased risk of communicable disease transmission when residents were not assisted with hand hygiene prior to receiving their meals.

Sources: Observations; IPAC Standard for Long-Term Care Homes; interviews with Personal Support Workers (PSWs), RPN, and the IPAC Lead.

(ii) According to 9.1 b) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices were followed in the IPAC program and at a minimum, included hand hygiene, including, but not limited to, at the four moments of hand hygiene; before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact.

Rationale and Summary
Observations in the dining rooms across multiple floors showed that several staff failed to perform hand hygiene when assisting residents to meals, with multiple missed moments of hand hygiene between tasks. Staff were observed reaching into the clean bin for clothing protectors and helping residents put them on without performing hand hygiene. Additionally, a visitor assisted a resident with a clothing protector, and another visitor retrieved a napkin from the servery without performing hand hygiene after assisting a resident.

IPAC Lead stated that both staff and visitors were required to perform hand hygiene

before and after contact with residents or their environment.

Failure to follow proper hand hygiene practices poses an increased risk of exposure to infection transmission.

Sources: Observations; IPAC Standard for Long-Term Care Homes; interviews with staff.

This order must be complied with by March 28, 2025

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Long-Term Care Inspections Branch

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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