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
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Original Public Report

Report Issue Date: July 5, 2023	
Inspection Number: 2023-1528-0005	
Inspection Type: Proactive Compliance Inspection	
Licensee: Ina Grafton Gage Home of Toronto	
Long Term Care Home and City: Ina Grafton Gage Home, Scarborough	
Lead Inspector Slavica Vucko (210)	**Inspector Digital Signature** Slavica Vucko Digitally signed by Slavica Vucko Date: 2023.07.10 13:24:15 -04'00'
Additional Inspector(s) Adelfa Robles (723)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 16, 19, 20, 21, 22, 23, 26, 27, 28, 2023

The following intake(s) were inspected:

- Intake: #00089875 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Recreational and Social Activities
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils

Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

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 (10) (b)

The licensee has failed to ensure that resident #011's plan of care related to their fall interventions was revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

Rationale and Summary
Resident #011's written plan of care indicated that resident was at high risk for falls. The fall interventions were not reflecting current condition of the resident.

At the time of the inspection, the resident was observed to have declined and required different fall prevention intervention than those in the care plan.

Staff indicated that the written plan of care was not updated with the current interventions.

There was an increased risk of injury to resident #011 when their plan of care was not updated to include their current care needs.

Sources: observations, review of resident #011's written plan of care, interviews with staff.

[723]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff involved in resident #010's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and

complemented each other.

Rationale and Summary
Resident #010's written plan of care indicated that resident had potential for pain due to specific health condition. On a specified date the resident verbalized pain to a staff and no further interventions were provided.

In a specified time-period the resident complained of pain at multiple occasions. The information about the resident's pain was not communicated to the nurses.

The staff were expected to communicate to nurses if a resident had complaints of pain and nurses were to complete an assessment and provide interventions as required.

Failure of the staff to collaborate in resident #010's different aspects of care related to pain management increased the risk of delayed treatment.

Sources: review of resident #011's clinical record, interviews with staff.
[723]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for resident #011 was followed related to their falls prevention and management interventions.

Rationale and Summary
During observations, resident #011 was noted without a specific fall prevention intervention as per the plan of care.

Resident #011's written plan of care indicated staff to implement a specific intervention to prevent injury. Resident #011 was at high risk for falls and had multiple falls within several months.

Staff did not apply the resident #011's fall management intervention and registered staff was not informed of any care refusals related to this intervention. Staff were expected to follow the resident #011's plan of care.

There was an increased risk of injury to resident #011 when their plan of care related to falls

management was not followed as specified.

Sources: review of resident #011's written plan of care, observations, interviews with staff.
[723]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary
There were three doors in the unit areas accessible to residents that were left unlocked, propped open, or with a key left in the keyhole. The doors were leading to non-residential areas such as the tub area, shower, soiled utility, supply (with oxygen and sharps container), clinic rooms and garbage chute.

The doors leading to the non-residential home areas should remain closed and locked at all times when not supervised by staff.

There was a risk to residents for potential injury if non-residential home areas were left unattended and unlocked.

Sources: observations, interviews with staff.
[723]

WRITTEN NOTIFICATION: Recreation and Social Activities

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 71 (2) (d)

The licensee has failed to ensure the program included opportunities for resident and family input into the development and scheduling of recreation and social activities.

Rationale and Summary
Resident #013 did not receive program activities as per their preference and needs.

The resident was not able to participate in all types of activities (group or individual) the home offered due to a specific medical reason.

The written plan of care for programs and activities, indicated the resident had specific needs to be engaged in activities and programs. Some of the preferred general activities were documented in the Minimum Data Set (MDS) assessment and not in the resident's written plan of care.

The resident participated in a specific activity during several occasions since admission. As per the resident's Substitute Decision Maker (SDM), the resident responded well on this specific therapy, and it was expected to be performed on regular basis. The written plan of care was not updated during a care conference. The home has an admission assessment form for assessment of the resident's preferences and it was not completed.

The home's policy Programs Development, Implementation and Evaluation, did not indicate a process for residents or residents' families to be involved in development and scheduling of activities for residents identified with a specific medical condition.

Failure of the home to ensure the program included opportunities for resident and family input into the development and scheduling of individualized recreation and social activities lead to inconsistent activities of the resident.

Sources: interview with resident #013's SDM, review of home's policy Programs Development, Implementation and Evaluation, PM H-70, dated February 2, 2023, resident 013's clinical record and interviews with staff.
[210]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

The licensee has failed to ensure that the food production system must at a minimum provide for communication to residents and staff of any menu substitution.

Rationale and Summary
On a specified date, the home's Standard Menu and the daily posted menu included mango mousse cake as a first option for lunch dessert. There was no mango mousse cake served during the entire lunch meal observation.

Dietary Aide (DA) #106 was not aware of any menu items substitution and did not compare the posted menu with the served dessert. The home's Dietary Manager (DM) confirmed the menu substitution.

The menu substitutions were not communicated to the staff and reflected in the posted menu to inform the residents.

Failure of the home to communicate menu substitutions do not reflect a resident centered care approach.

Sources: meal observation, IGGH Standard Menu F/W 2022-23 Week 2, Daily Posted Menu, interviews with staff.
[723]