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

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| **Report Issue Date:** August 30, 2023 | |
| **Inspection Number:** 2023-1528-0006 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident | |
| **Licensee:** Ina Grafton Gage Home of Toronto | |
| **Long Term Care Home and City:** Ina Grafton Gage Home, Scarborough | |
| **Lead Inspector**<br>Parimah Oormazdi (741672) | **Inspector Digital Signature**<br>Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2023.09.08 11:04:23 -04'00' |
| **Additional Inspector(s)**<br>Lisa Salonen Mackay (000761) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-17, 21-22, 2023.
The inspection occurred offsite on the following date(s): August 18, 2023.

The following intake(s) were inspected:

- Intake: #00090227 was related to falls prevention and management.
- Intake: #00093249 was related to prevention of abuse and neglect.
- Intake: #00093675 was related to prevention of abuse and neglect.
- Intake: #00093281 was related to prevention of abuse and neglect.

The following intakes were completed in the Critical Incident System Inspection:

- Intake: #00089556 was related to falls prevention and management.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

**NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)**
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care reviewed and revised when the resident's care needs changed.

**Rationale and Summary**
A resident sustained a fall that resulted in an injury and transfer to hospital. The Physiotherapist (PT) assessed the resident upon their return from hospital and recommended use of a fall prevention equipment. The written care plan of the resident was not revised and updated with PT's recommendation of the fall prevention equipment.

A Personal Support Worker (PSW), Nurse Manager (NM) and the PT stated the fall prevention equipment was in place. PT acknowledged it was not included in the resident's care plan and it was updated afterward, during the inspection.

Failure to update and revise the resident's plan of care put them at risk of subsequent falls and injury.

**Sources:** Resident's clinical record, Critical Incident (CI) report, interviews with a PSW, NM and the PT. [000761]

Date Remedy Implemented: August 16, 2023

## WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 103 (a)

The licensee has failed to ensure that assessment of a resident after report of allegation of physical abuse was documented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a procedures and interventions to assist and support residents who have been allegedly abused.

Specifically, the home did not comply with the “Abuse and Neglect Policy", which was included in the licensee’s zero tolerance of abuse and neglect Program. .

**Rationale and Summary**
A resident's Substitute Decision Maker (SDM) reported to the Nurse Practitioner (NP) an allegation of physical abuse by a PSW to the resident. The NP did an assessment of the resident, however they did not document the assessment of resident in the home's clinical electronic system, Point Click Care (PCC).

The home's Abuse and Neglect Policy indicates that "The first step of the investigation is to protect the resident. As such, the Executive Director /designate, and a physician, if necessary or requested, is to meet with the resident to ensure the health and safety of the resident and to conduct a brief, preliminary interview. If a physician examines the resident, a report is to be prepared and provided to the Executive Director /designate."

A Registered Practical Nurse (RPN) indicated that they were not aware of the incident when they started their shift since the assessment of resident was not documented in PCC. The NP confirmed that they did not document the assessment of resident in PCC. The Director of Nursing (DON) indicated when an allegation of physical abuse is being reported, the expectation of home is to document the assessment of resident using a tool in the PCC. They confirmed that the resident's assessment after the report of abuse should have been documented in PCC.

Failure to document the assessment of the resident following the allegation of abuse caused inconsistency in monitoring the resident.

**Sources:** Interviews with a RPN, the NP and DON, resident's clinical records, home’s abuse and neglect Policy.

[741672]

## WRITTEN NOTIFICATION: HOUSEKEEPING

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 93 (2) (d)

The licensee has failed to ensure addressing lingering offensive odours in a resident's room.

**Rationale and Summary**
It was observed that a resident was watching TV inside their room while there was a strong odour of urine in their room. The resident indicated that the odour has been long lasting in their room and was offensive to them.

The Environmental Service Manager (ESM) indicated that a special chemical should have been used to address the lingering urine odour. They verified that the product has not been used when the housekeeping staff cleaned the resident's washroom. The Director of Nursing (DON) confirmed that it was not acceptable to leave the resident inside their room with the strong odour of urine.

Failure to address the lingering urine odours leaves the resident's room in an undignified state of condition.

**Sources:** Observation of the resident, interviews with resident, the ESM and DON.

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