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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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: November 22, 2023	
Inspection Number: 2023-1528-0008	
Inspection Type: Complaint Critical Incident	
Licensee: Ina Grafton Gage Home of Toronto	
Long Term Care Home and City: Ina Grafton Gage Home, Scarborough	
Lead Inspector Nrupal Patel (000755)	**Inspector Digital Signature** Nrupal Patel Nrupal Patel 2023.11.23 09:37:00 -05'00'
Additional Inspector(s) Yannis Wong (000707) Britney Bartley (732787)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-10, 14-15, 2023.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00097281 - [Critical Incident System- 3034-000018-23] - related to a disease outbreak.
- Intake: #00100200 - [Critical Incident System- 3034-000026-23] - was related to falls prevention and management.
- Intake: #00098174 - [Critical Incident System- 3034-000021-23] - was related to falls prevention and management.

The following Complaint intake(s) were inspected:

- Intake: #00098783 - related to alleged improper/incompetent care and fall resulting in injury.
- Intake: #00098801 - related to alleged improper/incompetent care.
- Intake: #00099093 - related to regarding a resident plan of care.

The following intake(s) were completed:

- Intake: #00099549 - [Critical Incident System-3034-000025-23] - was related to falls prevention and management.

- Intake: #00098242 - [Critical Incident System- 3034-000022-23]- was related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the home's policies, developed for the falls prevention and management program to ensure residents are monitored after a fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the home's falls prevention assessment policy related to monitoring residents, was complied with.

Specifically, a staff member did not comply with the policy "Fall Risk Assessment Policy", last revised September 2022, that directed staff to complete Head Injury Routine (HIR) monitoring for unwitnessed falls.

Rationale and Summary
A resident had an unwitnessed fall. The morning Unit Supervisor, Registered Practical Nurse (RPN) responded to the incident and did not initiate HIR monitoring for the resident. The evening Unit Supervisor, RPN, and Nurse Manager (NM) confirmed they were not informed by RPN of the resident's fall.

Upon becoming aware of the resident's fall from the resident's Substitute Decision Maker (SDM), another RPN initiated the Head Injury Routine (HIR) at a later date and time.

The home's "Fall Risk Assessment Policy" states when a resident has an unwitnessed fall, the registered staff is to complete HIR monitoring at prescribed intervals. NM and Executive Director confirmed RPN did not follow the home's policy and put the resident at risk when they did not initiate the HIR monitoring immediately.

The staff's failure to ensure that HIR monitoring was initiated immediately after the unwitnessed fall could lead to delay in identifying head injury and receiving treatment.

Sources: Resident's clinical records; interviews with staff; and the home's "Fall Risk Assessment Policy" last revised September 24, 2022

[000707]

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when resident had a fall, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary
Resident had an unwitnessed fall. The morning Unit Supervisor, Registered Practical Nurse (RPN) responded to the incident and did not document a post-fall assessment or any information to indicate the resident had a fall.

Upon becoming aware of the resident's fall in the following shift, Nurse Manager (NM) completed and documented the post-fall assessment.

The home's "Fall Risk Assessment Policy" states when a resident has a fall, the registered staff is to perform a head-to-toe assessment of the resident prior to moving them and complete documentation. The NM and Executive Director confirmed RPN did not follow the home's policy and put the resident at risk when a post-fall assessment was not completed.

The home's failure to ensure that a post-fall assessment was documented when resident had a fall resulted in a delay in identifying any injuries and receiving treatment.

Sources: Resident's clinical records; interviews with staff; and the home's "Fall Risk Assessment Policy" last revised September 24, 2022

[000707]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program.

Rational and Summary

A resident was seen seated at the dining table. The resident was then observed leaving the dining room and touching an identified object with their hands.

At specific time, Registered Nurse (RN) assisted the resident in returning to the dining table. The resident was not offered or assisted with hand hygiene by the RN and Personal Support Worker (PSW) when they returned and received their meal.

The RN and PSW confirmed that they did not assist resident with hand hygiene before meals.

The Infection Prevention and Control (IPAC) Manager and Director of Care (DOC) acknowledged that staff must assist with hand hygiene for resident before meals.

Failure to assist the resident with hand hygiene before meals puts them at risk for infection.

Sources: Observations on an occasion; Interviews with RN, PSW, IPAC Manager and the DOC.

[000755]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to respond to every verbal complaint made to the licensee or a staff member concerning the care of a resident within 10 business days of the receipt of the complaint.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint from a resident's Substitute Decision Maker (SDM) about the lack of response from the home regarding a number of verbal complaints they made about the resident's care.

The home acknowledged both of the SDM's verbal complaints and informed them an internal investigation would be initiated for each concern. The home submitted a Critical Incident Report (CIR) to the Director on the same day of receiving each complaint.

A review of relevant records, there was no information to support the home responded to resident's SDM about their concerns. The Executive Director (ED) stated they had made unsuccessful attempts to call resident's SDM but was unable to produce any documentation to support this. The ED confirmed the home has not provided a response to the resident's SDM about the complaints.

The home failed to inform the resident's SDM of the results of the home's investigation and any follow-up actions related to their verbal complaints. The home's failure to appropriately respond to the verbal complaints made by resident's SDM led to their inability to fully participate in the development and implementation of the resident's plan of care.

Sources: CIR #3034-000021-23; CIR #3034-000023-23; resident 's progress notes; home's investigation notes; interview with ED

[000707]