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

Original Public Report

Report Issue Date: January 23, 2024	
Inspection Number: 2023-1528-0009	
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 Britney Bartley (732787)	**Inspector Digital Signature** Britney Bartley Digitally signed by Britney Bartley Date: 2024.01.25 15:58:29 -05'00'
Additional Inspector(s) Irish Abecia (000710)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4, 5, 8 - 12, 2024.

The following intake(s) were inspected:

Intake: #00100847 - Abuse from unknown staff towards a resident.
Intake: #00102083 - Related to COVID-19 outbreak.
Intake: #00102515 - Related to a fall of a resident with injuries.
Intake: #00102731 - A complaint related to multiple concerns.
Intake: #00103502 - Improper care of a resident related to multiple concerns.

The following intake were completed in this inspection: Intake #003451 related to a fall with injury.

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

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

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) (c)

Plan of care

When reassessment, revision is required

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,

(c) care set out in the plan has not been effective.

The licensee has failed to ensure a resident was reassessed and the plan of care reviewed and revised when their fall prevention strategy was ineffective.

Rationale and Summary:

A resident electronic record indicated the use of a safety device was initiated. This was implemented as a fall prevention strategy because the resident had experienced recent falls with injuries. A review of the resident's health record indicated they had a behaviour of removing the safety device on multiple occasions, this was documented by a Nurse Manager (NM).

Personal Support Worker (PSW) #120 stated they had seen the resident remove their safety device on several occasions. PSW #109 and a Registered Practical (RPN) stated the resident removed the safety device. An RPN and PSW #109 confirmed the intervention was ineffective as the resident can remove the safety device.

The NM acknowledges the safety device was not an effective intervention for any residents who would remove the equipment and that another alternate type of intervention could have been implemented.

By the home's failure to reassess and update a resident's plan of care they were placed at risk of harm when their falls prevention interventions were not effective.

Sources: A resident's clinical records, interviews with PSWs #120, #109, a RPN and the NM.

[732787]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that they immediately forwarded to the Director

any written complaint that it received concerning the care of a resident where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

Rationale and Summary

The home received a complaint from a resident's Substitute Decision Maker (SDM), relating to multiple concerns about the resident's care.

The home had contacted the Ministry's method for after-hours emergency contact ten days after the receiving the complaint. Subsequently, a Critical Incident (CI) report was submitted to the Director two days after the home called the Ministry's after-hours. The Executive Director (ED) confirmed the date the home received the complaint, and acknowledged that the complaint should have been immediately forwarded to the Director.

The home's failure to immediately forward the complaint to the Director concerning the care of a resident may have delayed follow up by the Ministry of Long-Term Care.

Sources: A resident's clinical records; and interview with the ED.

[000710]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect the abuse of a resident by staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Rationale and Summary

The home received a complaint from a resident's SDM that included allegations of physical harm to a resident on multiple dates.

A CI report was submitted to the Director. There was no report to the Ministry's method for after-hours emergency contact. A NM confirmed the date the home received the letter from a resident's SDM and acknowledged that it was not immediately reported to the Ministry.

The home's failure to immediately report to the Director concerns that alleged physical harm to a resident may have delayed follow up by the Ministry of Long-Term Care.

Sources: Resident's clinical records; and interview with the NM.

[000710]

WRITTEN NOTIFICATION: Skin and Wound

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received an assessment of their altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

Rationale and Summary

A resident had altered skin integrity on various parts of their body. As per the documentation, the resident's altered skin caused some discomfort. The resident currently still has altered skin on various parts of their body that will require further interventions.

The Long-Term Care Home's (LTCH's) policy stated nurses are to document their skin and wound assessment using the electronic wound documentation system that included taking a picture of the wound.

RPN #107 and #110 indicated they were aware the resident had various altered skin concerns on their body and had a prescribed treatment to apply base on a physician order. Both nurses stated they did not complete the initial or weekly electronic skin and wound assessment because those assessments are not done for this type of altered skin integrity or unless it is infected. When questioned on how they were

assessing the resident's altered skin, they both noted the application of the ordered treatment was their assessment.

A NM acknowledges there was no initial or weekly electronic skin and assessment done for the resident's altered skin and that the assessment should be completed for any altered skin integrity.

Failure of the home not completing the initial and weekly electronic skin and wound assessment put the resident at risk for not accurately assessing the healing and spreading of resident's skin concerns.

Sources: A resident's clinical records, LTCH's Skin Care & Wound Management Program Policy, last revised May 18, 2023, interviews with RPNs #110, #107, the NM and other staff.

[732787]