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: October 15, 2024

Inspection Number: 2024-1528-0002

Inspection Type:
Complaint
Critical Incident

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): September 10, 11, 12, 13, 16, 17, 18, 19, 2024.

The following intakes were inspected in the complaint inspection:

- Intake: #00120299 related to concerns regarding resident neglect, and Infection Prevention and Control (IPAC) program.
- Intakes: #00124886 and #00126523 related to Director of Care (DOC) qualifications

The following intakes were inspected in the Critical Incident System (CIS) inspection:

- Intakes: #00121991/CIS#3034-000018-24 and #00122260/CIS#3034-000019-24 related to residents fall.
- Intakes: #00122595/CIS#3034-000022-24 and #00124006/CIS#3034-000027-24 related to Improper transfer of residents.
- Intake: #00123216/CIS#3034-000024-24 related to physical abuse from staff towards a resident.

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Falls Prevention and Management
Resident Charges and Trust Accounts

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure a resident's plan of care provided clear directions to staff related to their use of a fall prevention intervention.

Rationale and Summary:
A resident's care plan directed the staff to provide a fall prevention intervention but

also stated that the resident would refuse to use the fall prevention intervention. An observation of the resident indicated that they were using their fall prevention intervention and a Personal Support Worker (PSW) stated they do not have any concerns providing the resident their fall prevention intervention. The Nurse Manager (NM) reviewed the resident's care plan and confirmed that the information may result in unclear directions to the staff members who may not be familiar with the resident's care, on whether this fall prevention intervention was to be provided or not.

Failure to ensure that the instructions on a resident's plan of care were clear may result in the resident not receiving the necessary interventions for reducing potential fall related injury.

Sources: A resident's care plan; an observation with the resident; Interview with the PSW and the NM.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure the resident's preferences related two specified areas of their activities of daily living (ADL) were reflected in their plan of care.

Rationale and Summary:
A Registered Practical Nurse (RPN) told the inspector that the resident would

demonstrate a specific preference for their ADLs. A review of the resident's care plan did not provide information about their specified preference of those ADLs. The NM confirmed that the resident's preferences for those ADLs should be reflected in their care plan.

Failure to ensure that the resident's care plan aligned with their preferences may result in reduced quality of life for the resident.

Sources: An observation on the resident; a resident's care plan; Interviews with a RPN and the NM.

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that two incidents of improper care of two residents were immediately reported to the Director.

Rationale and Summary:
i) A resident made an allegation that they received improper care from an PSW. On that same day, the RPN stated they informed the NM about the allegations as soon as they were made aware of the incident. The incident was not reported to the

Director until a day later.

Sources: A CIS report; Interview with a RPN and the NM.

Rationale and Summary
ii) A resident had a fall and sustained an injury. The home conducted an investigation and found that it was caused from improper care by the PSW. The Director of Care (DOC) confirmed the home had reasonable grounds to suspect that improper care occurred and should have immediately reported this to the Director.

Failing to immediately report this incident of improper care put the residents at risk for further harm as the Director could not respond to ensure appropriate measures had been taken to prevent reoccurrence.

Sources: A resident's clinical records, the home's investigation notes and interview with DOC.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their Falls Prevention and Management policy related to post fall assessment.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with.

Specifically, staff did not comply with the home's policy "Fall Risk Assessment" dated February 2024.

Rationale and Summary
A resident had a fall, resulting in an injury.

The home's policy titled "Fall Prevention Program" indicated that post fall assessment was to be completed in a specified manner related to the intervals of time. Review of the resident's clinical records indicated post fall assessments were not completed in accordance to the home's policy.

The DOC indicated that it was expected acknowledged that assessments were not completed as required.

Failure to complete post fall assessment in accordance with home's policy, placed the resident at risk of not properly assessed for post fall complications.

Sources: Review of the home's policy "Falls Prevention Program" dated February 2024, a resident's clinical records, interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 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 an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident's altered skin integrity was assessed using the home's clinically appropriate assessment instrument.

Rationale and Summary:
A resident had been experiencing an altered skin integrity concern.

The home's policy titled, "Skin Care & Wound Management Program" dated May 2023 indicates that for any altered skin integrity issues identified, that an electronic documentation tool would be used.

A review of the assessments on the resident's electronical documentation tool did not indicate that an assessment was completed when the physician had identified that the altered skin integrity was present. The NM stated that based on the home's policies and protocols, a skin assessment on the electronical documentation tool would need to have been completed when the physician identified that the resident's altered skin integrity had been present.

Failure to assess the resident's altered skin integrity may lead to missed opportunities to implement effective interventions.

Sources: A resident's electronic documentation profile; Home's policy titled, "Skin

Care & Wound Management Program" dated May 2023; Interview with the NM.

WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 250 (3) (b)
Director of Nursing and Personal Care
s. 250 (3) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care,
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and

The licensee has failed to ensure that an individual hired as a DOC has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

Rationale and Summary
The home hired a DOC to work in the home as the Acting DOC in April 2024. The DOC worked in the home for a period of approximately three months from April 2024 to June 2024. At the time of hiring, the facility did not verify whether the DOC met the minimum requirement of three years of experience as a registered nurse in a managerial or supervisory capacity within a healthcare setting.

A review of the DOC's resume showed that they did not have the minimum requirement of three years of relevant managerial/supervisory experience at the time the DOC position was offered to them. Furthermore, the home was unable to provide any additional documentation or information to substantiate that the DOC met the necessary criteria for this position.

Failure to ensure compliance with staffing qualifications for the DOC role posed risk of poor management of resident care and facility operations.

Sources: A DOC's resume, and interview with Vice President of Operations.

WRITTEN NOTIFICATION: Orientation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (1) 2.
Orientation
s. 259 (1) For the purposes of paragraph 11 of subsection 82 (2) of the Act, the following are additional areas in which training shall be provided:
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

The licensee has failed to ensure a PSW was provided training and orientation on safe and correct use of equipment including mechanical lifts under paragraph 11 of subsection 82 (2) of the Act.

Rationale and Summary
A resident sustained an injury during a transfer, provided by a PSW.

The home was requested to provide training records for the PSW regarding their training and orientation on safe and correct use of mechanical lifts; however, the home was unable to produce any written records of staff participation in the training and orientation program. The PSW acknowledged that they did not receive any training from the home on the safe lift and transfer program.

Failing to ensure that the PSW was provided training on use of mechanical lifts upon being hired, increased the risk of staff not using the equipment safely.

Sources: The CIS report, home's policy titled "Orientation Agency Personnel" dated May 2024, a resident's clinical records, home's internal investigation notes, interviews with the PSW, the NM and other staff.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The license shall:

1.Educate the DOC on the steps that are required to be taken when an investigation is required based on the home's abuse and neglect policy.
2.Audit at least one investigation conducted by the DOC that was completed after the issuance of this order. If no recent investigations are available, audit any previous investigations that were conducted by the DOC in the past three months. The audit must identify any gap(s) which the investigation did not align with the home's abuse and neglect policy and the actions taken to address these gap(s).
3.Ensure the DOC and/or a designate informs a resident on the outcomes of the

home's investigation into their allegation of improper care and how the outcomes were reached. This step must be documented and include actions taken.
4.Educate a PSW on the reporting requirements based on the home's abuse and neglect policy.
5.Maintain a record of the education and audit conducted for steps 1, 2 and 4, including the date of the audits and person(s) who were involved in the process of providing the education and conducting the audits.

Grounds
The licensee failed to ensure that the home's written policy related to zero tolerance of abuse and neglect of residents as complied with.

Rationale and Summary:
i) A resident alleged that a PSW was providing improper care. The resident stated they were not aware of the outcomes related to the allegations they made.

The home's abuse and neglect policy indicated that the Executive Director (ED)/delegate was responsible for informing the outcomes of an alleged abuse incident to the resident. The DOC who conducted the investigation into this incident could not provide any information to support that the ED provided an outcome of the investigation to the resident.

Failure to inform the resident on the outcomes of an alleged incident of staff to resident abuse may result in the resident having a diminished sense of safety.

Sources: Home's abuse and neglect policy, dated April 2024; Interview with a resident, two staff members and the DOC.

ii) In the home's investigation into an incident related to improper care of a resident,

a PSW stated in their interview that another PSW and a RPN were present with them on day of the incident. These individuals stated they were not interviewed by the home about this alleged incident.

The home's abuse and neglect policy states, "The person making the report and the resident are to be the first persons to be interviewed. Thereafter, the respondent and any other witnesses are to be interviewed". The DOC confirmed that the home's abuse and neglect policy was not followed.

Failure to interview and investigate all individuals involved in an alleged incident of staff to resident abuse may result in lost opportunities to gather information to take appropriate actions in response to an alleged incident of improper care.

Sources: Home's abuse and neglect policy, dated April 2024; Interview with a PSW, a PSW, the RPN and the DOC.

iii) A PSW stated that a resident had concerns that another staff member was providing improper care to them. The PSW stated they had not reported this information to anyone and could not identify when this incident exactly occurred.

The home's abuse and neglect policy stated, "Where a staff member has reason to believe that a resident has suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the Home".

The PSW stated they were aware that they were to report this allegation immediately to their supervisor but did not do so in this situation.

Failure to report an allegation of resident abuse immediately may result the home's ability to respond and put in place interventions for resident safety.

Sources: Home's abuse and neglect policy, dated April 2024; Interview with a PSW and the NM.

This order must be complied with by November 21, 2024

COMPLIANCE ORDER CO #002 Transferring and positioning techniques

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1. Re-educate all PSWs and registered staff working in the home related to the home's home's Mobility and Minimal Lift Program policy. The training should include safe transferring and positioning techniques during all aspects of resident's care. Staff must demonstrate to the home safe transferring and positioning techniques after the completion of the training.
2.The home must maintain a record of above education and demonstration of safe transferring and positioning techniques including date of education and demonstrations, who provided the education, signed attendance sheet for

education and the content of education.
3. Conduct daily audits of PSWs transfer techniques both day and evening shifts on second and third floors to ensure safe transfer and positioning of residents for a minimum period of four weeks or longer if further concerns are identified.
4. The home must maintain a record of above audits, including the date of observation, who completed the observation, and any corrective action.

Grounds
The licensee has failed to ensure that staff used safe transferring techniques for two residents.

Rationale and Summary
i) A resident was not transferred in accordance to their plan of care and resulted in them falling and sustaining an injury.

The home's policy titled "Safe Operating Procedure" index #Q-05-40 last revised in April 2023, indicated a specified manner to transfer residents.

The PSW stated they had attempted to follow the resident's transfer status as per their plan of care, however, they were unable to do so and that it was common practice in the home to have staff not to follow the policy related to transferring residents.

The resident sustained an injury as a result of PSW not adhering to the resident's transfer status and the home's policy.

Sources: The CIS report, a resident's clinical records, home's investigation notes, interviews with a PSW, the NM and other staff.

ii) A resident's progress notes indicated that a PSW provided a transfer to the resident that did not align with their assessed transfer status. As a result, the resident sustained a fall during the transfer.

The PSW acknowledged that they did not provide a transfer that aligned with the resident's assessed transfer status from their plan of care.

The PSW provided an unsafe transfer to the resident resulted in them falling.

Sources: A CIS report, a resident's clinical records, home's investigation notes, interviews with the PSW, the DOC and other staff.

This order must be complied with by November 21, 2024

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.