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

Public Report

Report Issue Date: January 21, 2025

Inspection Number: 2025-1528-0002

Inspection Type:
Complaint

Licensee: Ina Grafton Gage Home of Toronto

Long Term Care Home and City: Ina Grafton Gage Home, Scarborough

INSPECTION SUMMARY

The inspection occurred on the following date(s): January 8-10, 13-17, 20-21, 2025.
The following intake(s) were inspected in this Complaints inspection:
• Intake: #00129602 – related to improper/incompetent care; documentation; and staffing

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

Resident Care and Support Services

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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care for a resident was documented on multiple days. Specifically, the use of a specialized device to treat a health condition.

Sources: Resident's clinical records; interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure a resident was protected from neglect by a Registered Nurse (RN).

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The resident's substitute decision-maker (SDM) approached an RN with concerns about the resident's health condition. The RN indicated they were unavailable and refused to assess, or speak with the other SDM regarding the resident's status. A Nurse Manager and the Nurse Practitioner were not informed that the resident was in need of an assessment during that time. As a result, the resident went without a

prompt assessment. The Nurse Consultant (NC) indicated that by failing to act and ensure the resident's well-being, the resident was neglected.

Sources: Resident's clinical notes; home's investigation notes; and interviews with staff.

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