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

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Public Report

Report Issue Date: April 14, 2025
Inspection Number: 2025-1528-0005
Inspection Type: Critical Incident Follow up
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 dates: April 10, 11, 14, 2025.

The following intakes were inspected:

- Intake: #00137713 - related to follow-up of Compliance Order (CO) #001 for Infection Prevention and Control;
- Intake: #00139011 - Critical Incident System (CIS) #3034-000004-25 – related to an outbreak;
- Intake: #00142864 – CIS #3034-000009-25 – related to an alleged incident of improper care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1528-0001 related to O. Reg. 246/22, s. 102 (7) 11.

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a Personal Support Worker (PSW) utilized safe positioning techniques with a resident.

A resident was positioned using an equipment while inside their room. The PSW left the resident unattended and when they returned, the resident fell from the equipment and sustained an injury. The PSW stated that they should not have left the resident unattended given the resident's risk factors and acknowledged their actions were unsafe.

Sources: Interview with a PSW and the Interim Director of Care (DOC); a resident's progress notes, care plan and assessments from PointClickCare (PCC).

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 (1)

Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the home's falls prevention and management program related to the head injury routine (HIR) monitoring after a resident sustained a fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's HIR policy under the home's falls program indicated that a resident would be monitored through observations and assessments, and have their vital signs taken after sustaining a fall with a head injury, which was not appropriately completed for a resident during a specified shift.

Sources: Home's policy titled, "Head Injury Routine", dated March 2025; Review of the HIR documentation for a resident; Interview with the Interim DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection

(2); and

The licensee has failed to ensure that on every shift, three residents' symptoms indicating the presence of infection were monitored during an outbreak that occurred in February 2025. Failure of staff to monitor the residents' symptoms of infection every shift, placed the residents at risk of delayed treatment of their infection.

Sources: Review of three residents' clinical records; and interview with the Infection Prevention and Control (IPAC) Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee has failed to ensure an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including reporting protocols based on requirements under the Health Protection and Promotion Act was followed.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the IPAC program were complied with. Specifically, the home’s policy indicated that two resident cases with symptoms onset within 48 hours with an epidemiological link are required to be reported to Toronto Public Health (TPH).

The home documented two symptomatic residents on a unit that presented with respiratory symptoms, which met the home's definition of a suspected respiratory outbreak. TPH was not notified of a suspected ARI outbreak until days later, as confirmed by the the IPAC Lead. By this date, six residents were symptomatic.

Sources: Home's policy "Outbreak Management" (November 2024), Respiratory outbreak line list (#3895-2025-00238), interview with IPAC Lead.