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: March 26, 2025
Inspection Number: 2025-1528-0004
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 onsite on the following date(s): March 3-7, 11, 12, 2025
The inspection occurred offsite on the following date(s): March 13, 14, 17-21, 24, 25, 2025
The following intake(s) were inspected:

- Intake: #00140958 - Complaint related to funding, staff qualifications and resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Social work and social services work qualifications

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 69
Social work and social services work qualifications
s. 69. Every licensee of a long-term care home shall ensure that social workers or social service workers who provide services in the home are registered under the Social Work and Social Service Work Act, 1998.

The licensee has failed to ensure that a Social Services Coordinator who provided social service work in the home was registered under the Social Work and Social Service Work Act, 1998.

A Social Services Coordinator provided social work services to residents, families and staff and was not registered with the Ontario College of Social Workers and Social Service Workers (OCSWSSW).

Sources: The home's staff directory, OCSWSSW website, staff records and an interview with the Social Services Coordinator. [501]

COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 3.
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:
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
Prepare a case study of failing to report the unlawful conduct of an Acting Director of Care (DOC). This review should include, but not be limited to:

Review and evaluate what constituted unlawful conduct in the above case including potential implications to residents resulting from failure to report, and consider if including a case study of failure to report such as this, would enhance the awareness and learning for each manager. Keep a written record of your evaluation and learning records for each manager.

Grounds

The licensee has failed to ensure that persons who had reasonable grounds to suspect unlawful conduct that resulted in a risk of harm to residents, immediately reported their suspicion to the Director.

A previous Acting Director of Care (DOC) resigned abruptly after receiving a call from the College of Nurses of Ontario (CNO). Shortly after, a previous Executive Director (ED), suspected that this Acting DOC had taken their personnel file. They reported this to the CNO but not to the Director.

A few months later a Toronto Police Services (TPS) Detective came to the home to inquire about this Acting DOC indicating that this person may not be who they said they were. A Nurse Consultant/Acting Director of Care who spoke with the Detective admitted that they should have reported this to the Director. This Nurse Consultant/Acting DOC also indicated that the previous ED should have reported the stolen file to the Director.

Failing to report these unlawful activities put residents at significant risk as a person had direct impact to their care and well-being.

Sources: Employee personnel records, CNO website, and interviews with a Nurse Consultant/Acting DOC and a TPS Detective. [501]

This order must be complied with by May 8, 2025

COMPLIANCE ORDER CO #002 Director of Nursing and Personal Care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 77 (2)
Director of Nursing and Personal Care
s. 77 (2) The Director of Nursing and Personal Care shall be a registered nurse.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

(a) A process to ensure that the College of Nurses of Ontario (CNO) resource tool "Find a Nurse" and the Unregistered Practitioner list is reviewed prior to hiring registered staff and/or any nursing manager position, including the Director of Care
(b) Before any existing registered staff become an Acting Director of Care or Director of Care, or employees of the home's contracted management company, they are rechecked with the CNO to ensure they are still registered and entitled to

practice
(c) A system to verify that certifications of education are authentic, references are validated, resumes are cross checked for consistency and interviews are conducted to address any irregularities for all those to become an Acting Director of Care/Director of Care
(d) Hiring coordinator and any individual who assists with hiring receives training on the above items

The plan should include identified staff roles and responsibilities for the implementation and evaluation of the above process. A timeline is to be established for the implementation of each component of steps (a) through (d) by the compliance due date.

Please submit the written plan for achieving compliance for inspection #2025-1528-0004 by April 10, 2025.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure an Acting Director of Care (DOC) was a registered nurse.

A previous Acting DOC worked at the home for a short period of time and resigned abruptly. Evidence revealed that they were not a registered nurse.

There was significant risk to residents and the operation of the home as an unregistered nurse had direct access to residents, families, personal health information and oversaw staff without the proper qualifications.

Sources: Employee personnel records, College of Nurses of Ontario (CNO) website, and interviews with a Nurse Consultant/Acting DOC and a Toronto Police Services Detective. [501]

This order must be complied with by May 8, 2025

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.