



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 18, 2015	2015_219211_0018	018243-15	Critical Incident System

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### **Licensee/Titulaire de permis**

INA GRAFTON GAGE HOME OF TORONTO  
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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### **Long-Term Care Home/Foyer de soins de longue durée**

INA GRAFTON GAGE HOME  
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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### **Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

JOELLE TAILLEFER (211)

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## **Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 10, 11, 2015.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (Acting) DOC(A), Assistant Director of Care (ADOC), Registered Nurses (RN), Personal Support Worker (PSW), Private Sitter, Family member and Resident.**

**During the course of the inspection, the inspector observed resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

**6 WN(s)**

**5 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**



1. The licensee has failed to 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.

Review of the home policy index P-10 titled "Abuse and Neglect Policy" revised July 2, 2015, indicated the Administrator and his/her designates are to conduct and document the interviews as part of the investigation.

Review of the critical incident and the progress notes on an identified date, revealed RN #111 observed resident #006 with an injury.

Interview with the Director of Care (Acting) DOC(A) revealed the investigation was started on an identified date, by the previous DOC at that time but the investigation notes were not found in the home.

The Administrator confirmed that the interviews of the investigation of the above incident were not documented and the home's abuse and neglect policy was not complied with.  
[s. 20. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to 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, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**



**Specifically failed to comply with the following:**

**s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

Review of the critical incident and progress notes on an identified date, revealed RN #111 observed resident #006 with an injury.

Interviews with RN #103 and RN #111 revealed the previous DOC was informed immediately of the incident.

Review of the Ministry of Health and Long-Term Care (MOHLTC) Incident Report indicated the Director was informed of the suspected abuse on an identified date.

Interview with the Administrator confirmed there was no documentation to indicate the Director was informed immediately of the suspected abuse on an identified date. [s. 24. (1)]



***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the whistle-blowing protections, at times or at intervals provided for in the regulations.

Review of the home's training binders for 2014 and interview with the Administrator revealed the training records could not be located and could not confirm all staff received the annual retraining in the above areas. [s. 76. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff have receive retraining annually relating to the following:***

- ***The Residents' Bill of Rights***
- ***The home's policy to promote zero tolerance of abuse and neglect of residents***
- ***The duty under section 24 to make mandatory reports***
- ***The whistle-blowing protections, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Review of the critical incident and progress notes on an identified date, revealed RN #111 observed resident #006 with an injury.

Review of the MOHLTC Incident Report indicated the Director was informed of the suspected abuse on an identified date.

Interview with the Administrator confirmed the police should have been immediately notified and there is no documentation to support that the police was called of the suspect abuse on an identified date. [s. 98.]



***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:**

- 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).**
- 2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).**

**Findings/Faits saillants :**

- 1. The licensee has failed to ensure that the staff who provide direct care to residents receive annual training in abuse recognition and prevention.**

Review of the home's training binders for 2014 and interviews with the Director of Care (Acting) and the Administrator revealed the training records could not be located and could not confirm all staff received the annual training in abuse recognition and prevention. [s. 221. (2)]





***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff who provide direct care to residents receive annual training in abuse recognition and prevention, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation**  
Every licensee of a long-term care home shall ensure,  
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;  
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;  
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;  
(d) that the changes and improvements under clause (b) are promptly implemented; and  
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

**Findings/Faits saillants :**



1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Interview with the DOC revealed the annual evaluation to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents was not carried out in 2014.

Interview with the Administrator confirmed the annual evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents should have been completed for the previous year. [s. 99. (b)]

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**Issued on this 7th day of December, 2015**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**