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: June 13, 2025
Inspection Number: 2025-1528-0006
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: June 9, 10, 11, 13, 2025.

The following intakes were inspected:

- Intake: #00143423 - related to follow-up of Compliance Order (CO) #001 for reporting certain matters to the Director;
- Intake: #00143422- related to follow-up of CO #002 for Director of Nursing and Personal Care;
- Intake: #00148129- Critical Incident System (CIS) #3034-000013-25 – related to fall prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1528-0004 related to FLTCA, 2021, s. 77 (2)
Order #001 from Inspection #2025-1528-0004 related to FLTCA, 2021, s. 28 (1) 3.

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

Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee has failed to ensure that a Personal Support Worker (PSW) was included in the Critical Incident Systems (CIS) report to the Director. A PSW found a resident after they sustained a fall, which subsequently led to a transfer to the hospital and a diagnosis of an injury. The Acting Director of Care (DOC) confirmed that the PSW should have been included in the CIS report to the Director.

On June 11, 2025, the CIS report was amended to include the name of the PSW.

Sources: Review of CIS report #3034-000013-25; Interview with a PSW and the Acting DOC.

Date Remedy Implemented: June 11, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff collaborated in the development and implementation of a resident's plan of care related to a fall prevention intervention.

A resident had returned to the home from the hospital and fall prevention interventions were to be implemented at the time of their return, however, the Associate Nurse Manager (ANM) had endorsed to the next shift staff to apply a fall prevention intervention. The PSW did not notify the Registered Practical Nurse (RPN) when it was optimal to apply the fall prevention intervention for the resident. The PSW acknowledged they could have asked their colleague to inform the RPN to apply the resident's fall prevention intervention.

Sources: Review of a resident's progress notes; Interviews with the ANM , a PSW and a RPN.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 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 ensure that staff complied with the home's falls prevention and management program related to 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 directed staff to monitor the resident through observations and assessments, and have their vital signs taken after sustaining a fall with suspected head injury and assess every hour for the first four hours after the fall. A resident sustained a fall and a HIR was initiated. The HIR was not completed for the next scheduled check.

Sources: Home's policy titled, "Head Injury Routine", dated March 15, 2025; Review of the HIR documentation for a resident for the fall; A resident's progress notes; Interview with the Acting DOC.