Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 13, 2022
Inspection Number 2022_1528_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Ina Grafton Gage Home of Toronto

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

Lead Inspector
Oraldeen Brown (698)

Inspector Digital Signature
Oraldeen C Brown
2022.06.07 23:55:22 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 22, 25-27, 2022

The following intake(s) were inspected:

- Log #003590-22, Critical Incident System (CIS) #3034-000005-22 was related to falls prevention and management and;
- Log #004285-22 was a complaint related to falls, plan of care and nutrition.

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

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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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (1) (a)
The licensee failed to ensure that there was a written plan of care for one resident that set out the planned care for the resident.

Rationale and Summary
The inspector observed fall interventions, including two specific interventions, in the resident's room. The resident's written plan of care did not include these interventions.

ADOC #103 identified that the resident's care plan should have been updated to reflect the above mentioned interventions that were already in place at the time. The written plan of care was revised and updated to include the interventions on April 25, 2022.

Date Remedy Implemented: April 25, 2022 (698)

COMPLIANCE ORDER [CO#001] PLAN OF CARE

NC#02 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021 s. 6 (7)

Specifically, the Licensee must:

1. Implement a process to ensure that staff monitor resident #001 for the presence of their specified fall prevention intervention on applicable shifts.
2. Conduct random audits to ensure the resident's above identified intervention is in place for a minimum of four weeks, or until no further concerns are identified.
3. The home must maintain a documented record for steps one and two, including the person responsible, date, time and outcome.

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Grounds

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Rationale and Summary

Resident #001 had a fall and was transferred to hospital where they were diagnosed with an injury. Staff were to make sure specified interventions were in place for the resident while up in the chair and while lying in bed.

On two separate occasions, the inspector observed the intervention was not in place for resident #001 while in their wheelchair.

ADOC #103 indicated Personal Support Workers (PSW) were to implement the above fall prevention intervention as per care plan.

As a result of staff failing to ensure the resident's fall intervention was in place, there was increased risk of fall with injury.

Sources: observations, resident #001's electronic records and paper charts, the home's Investigation Notes, Critical Incident System (CIS) report, the home's policy titled "Care Plan and Plan of Care" revised February 16, 2022, interview with ADOC #103 and others. [698]

This order must be complied with by May 27, 2022

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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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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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
email: 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.