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

Original Public Report

Report Issue Date: September 29, 2023

Inspection Number: 2023-1528-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Ina Grafton Gage Home of Toronto

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

Lead Inspector	**Inspector Digital Signature**
Lisa Salonen Mackay (000761)	Lisa A Salonen Mackay Digitally signed by Lisa A Salonen Mackay Date: 2023.10.04 13:23:48 -04'00'

Additional Inspector(s)
Manish Patel (740841)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18, 19, 20, 22, 26, 2023
The inspection occurred offsite on the following date(s): September 25, 2023

The following intake(s) were completed in this Critical Incident (CI) inspection:
Intake: #00094122/CI#3034-000014-23; Intake: #00094124 /CI#3034-000015-23 and Intake: #00096779 /CI#3034-000017-23 were related to falls prevention and management.

The following intake was completed in this complaint inspection.
Intake: #00095120 was related to resident care, continence care, skin and wound prevention and management, infection prevention and control, responsive behaviours and falls prevention and management.

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

Resident Care and Support Services
Continence Care

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
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)
O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted in an accurate and timely manner as per home's "Fall Prevention Program".

Rationale and Summary:
A Critical Incident (CI) was submitted for a resident who had fallen.

As per the "Fall Prevention Program", registered staff are required to document assessment immediately post-fall. A post-fall assessment was late. A registered staff confirmed that incomplete documentation was done immediately post-fall.

A Manager acknowledged that registered did not post-fall assessment immediately as per home's "Fall Prevention Program".

Failure to complete a post-fall assessment in timely manner when a resident fell, created a potential risk of accurate information identifying all factors that contributed to the resident's fall to prevent, manage, and reduce future incidence of falls and the risk of injury being missed.

Sources: Review of resident clinical record; Fall Prevention Program; interviews with staff.

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Date Remedy Implemented: During Inspection

WRITTEN NOTIFICATION: Safe Transfer

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that the staff used safe transferring when assisting a resident.

Rationale and Summary:
A Critical Incident (CI) was submitted for a resident who had fallen.

Documentation review and interview with a staff confirmed the two staff members transferred a resident from the floor post-fall without an assessment by a registered staff.

A staff acknowledged a resident was transferred post-fall without an assessment by the registered staff. A Manager confirmed that staff unsafely transferred the resident off the floor. The expectation is that they should wait for an assessment by registered staff prior to moving a resident.

The “Fall Prevention Program” states an assessment of a fall must be done immediately following the fall by registered staff before moving the resident.

Failure to complete an assessment of the fall by a registered staff before moving the resident put them at risk for further injury.

Sources: Review of LTCH’s investigation notes; Fall Prevention Program; interviews with staff.
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