Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: July 22, 2024
Inspection Number: 2024-1528-0001
Inspection Type: Complaint Critical Incident
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): June 27, 28, 2024 and July 2, 3, 4, 5, 8, 9, 10, 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00110108 - [Critical Incident (CI): 3034-000007-24]- Fall with injury
- Intake: #00113144 - Complainant related to neglect/improper care
- Intake: #00115252 - [CI: 3034-000011-24] - Unknown etiology fracture
- Intake: #00115288 - [CI: 3034-000012-24] - Respiratory outbreak
- Intake: #00115367 - [CI: 3034-000013-24]- Improper care

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

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

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Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected.

In accordance with the definition identified in section 7 of the Ontario Regulation 246/22 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
A resident was found with a change in status. As a result, they were transferred to the hospital where they were diagnosed with an acute condition. Personal Support Worker (PSW) stated that they removed the resident's assistive device even though they were aware that they were not allowed to remove it. They immediately noted that the resident was having change in status. Additionally, they stated that the resident asked them to call the nurse to re-apply the assistive device. The PSW

called Registered Practical Nurse (RPN) three times. The RPN did not attend to the resident until the third time they were called when the resident was found very unwell.

The RPN stated that it was the nurse's responsibility to remove the resident's assistive device. They acknowledged that they did not attend to the resident when called by the PSW and by several other staff stating that the resident was calling.

The Nurse Practitioner (NP) stated that if the RPN has attended to the resident sooner, the change in status may have been prevented if the assistive device was applied earlier.

Nurse Manger (NM) stated that when the resident exhibited change in status and the RPN was called, they were required to attend to the resident immediately and complete an assessment and implement interventions for resident's safety.

Due to the inaction of RPN, when the resident had a change in their health status, the resident 's safety was jeopardized leading them to become unwell requiring further medical attention at the hospital.

Sources: Resident's clinical records, interviews with PSW, RPN , NP and NM.

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WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 77 (1)
Director of Nursing and Personal Care
s. 77 (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care.

The licensee has failed to ensure that the long-term care home had a Director of Nursing and Personal Care.

Rationale and Summary
Executive Director (ED) stated that previous DONPC resigned June 6, 2024 and no one has been working in DONPC's capacity at the Long-Term Care Home (LTCH) since then. The home did not have a DONPC during the inspection.

There was an increased risk of decreased supervision and direction to the LTCH's nursing and personal care staff, as well as lack of oversight over the provision of residents, when there was no DONPC in place.

Sources: Vacant DONPC position job posting, and interview with the ED.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Section 7.3, "the licensee shall ensure that the IPAC Lead plans, implements, and tracks the completion of all IPAC training and ensures that audits were performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role".

Rationale and Summary
(i) The LTCH was unable to provide the inspector with specific IPAC practice audits conducted regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

Failure to conduct IPAC practice audits increased the risk of staff not adhering to appropriate infection control protocols, potentially leading to the spread of infectious diseases among residents and staff members.

Sources: LTCH's IPAC audits, and interview with IPAC Manager.

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Specifically, Section 2.1, "the licensee shall ensure that the IPAC Lead conducts at a minimum, quarterly real-time audits of specific activities performed by staff in the home, including but not limited to, hand hygiene, selection and donning and doffing of PPE.

Rationale and Summary

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(ii) The LTCH was unable to provide the inspector with specific IPAC practice audits conducted quarterly to ensure that specific activities performed by staff in the home including selection and donning and doffing of Personal Protective Equipment (PPE).

Failure to conduct IPAC PPE audits increased the risk of staff not adhering to appropriate infection control protocols, potentially leading to the spread of infectious diseases among residents and staff members.

Sources: LTCH's IPAC audits, and interview with IPAC Manager.

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