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
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Public Report

Report Issue Date: September 12, 2025
Inspection Number: 2025-1528-0008
Inspection Type: 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): September 3, 4, 5, 8, 9, 12, 2025
The inspection occurred offsite on the following date(s): September 11, 2025

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00154063/CIS#3034-000022-25 related to falls prevention and management
- Intake: #00154167/CIS#3034-000023-25 related to suspected abuse to a resident

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the resident's written plan of care set out clear directions to staff and others who provide direct care to the resident.

The Inspector observed a resident, without a specific device. The registered nurse, Nurse Manager and rehabilitation staff indicated the resident would require the device at times, based on their level of alertness. The resident's plan of care did not set directions to staff on when to provide the resident with the specific device.

Sources: Observation; resident's plan of care; and interviews with RN, NM, and rehabilitation staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the resident had a fall prevention intervention in place, as specified in their plan of care.

The Inspector observed a resident's room and a specific fall prevention intervention was not in place. According to the resident's plan of care, a specific fall prevention intervention should have been in place. The NM confirmed the intervention should have been in place and acknowledged the plan of care was not followed.

Sources: Observations; resident's plan of care; and interview with NM.

WRITTEN NOTIFICATION: Duty to Protect

NC #003 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 protected from physical abuse by Personal Support Worker (PSW).

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

The resident sustained an injury during care. The resident stated the PSW intentionally hurt the resident. Unit Supervisor (US) acknowledged that on the day of the incident, the resident pointed at the injury and the PSW. NM confirmed during investigating the incident, no injury was observed on the resident prior to care.

Sources: CIS and interviews with the resident, US, and NM.

WRITTEN NOTIFICATION: Availability of Supplies

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The licensee has failed to ensure a specific device was available to meet the care needs of a resident.

The inspector observed the resident without a specific device. The rehabilitation staff and NM confirmed the device was not available for the resident to ambulate.

Sources: Observation; and interviews with the rehabilitation staff and the NM.