Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 28, 2017 | 2017_575214_0008 | 009707-17 | Resident Quality Inspection |

### Licensee/Titulaire de permis

Niagara Ina Grafton Gage Village
413 Linwell Road St. Catharines ON L2M 7Y2

### Long-Term Care Home/Foyer de soins de longue durée

INA GRAFTON-GAGE HOME
413 Linwell Road St Catharines ON L2M 7Y2

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CATHY FEDIASH (214), ROSEANNE WESTERN (508)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): May 25, 26, 29, 30, 31, June 1, 2, 6, 7, 8, 9, 12, 13, 2017.**

**The following onsite Inquiry was conducted concurrently with the RQI: 009611-17 related to Medication management.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO); Director of Care (DOC); Environmental Services Manager (ESM); Administrative Assistant Finances; Activity and Programs lead; registered staff; Personal Support Workers (PSW); President of Residents' Council; a member of the Family Council; residents and families. During the course of the inspection, the Inspectors toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; observed residents during care and dining service and observed the administration of medications.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Personal Support Services**
**Residents' Council**
**Skin and Wound Care**
**Sufficient Staffing**
**Trust Accounts**

**During the course of this inspection, Non-Compliances were issued.**

**9 WN(s)**
**3 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**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,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of resident #003's clinical record indicated that while using an identified mobility device to perform an activity of daily living (ADL) on a specified date, the resident was not able to support their weight and the resident was lowered to the floor. No injuries were identified.

A review of the resident's written plan of care indicated that following this incident, the resident was assessed and determined that the identified mobility device would no longer be used and that the resident would no longer participate in the transfer to complete the identified ADL but would receive care in their bed with specified interventions. The plan indicated that staff would check the resident at established times and if the resident rings, would offer care using specified interventions.

A review of the resident's written plan of care indicated that the resident would ring their call bell when they wished to be transferred to participate in the identified ADL.

An interview with front line nursing staff #113 on a specified date, indicated that the resident used a different mobility device than had been indicated to participate in the identified ADL.

An interview with the DOC on an identified date, indicated that the resident no longer used the identified mobility device to participate in the identified ADL and that the resident was now receiving care for this ADL in their bed. The DOC confirmed that the written plan of care for resident #003 had not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, different approaches were considered in the revision of the plan of care.

Resident #005 was assessed with an identified level for risk of falling on a specified date. Falls prevention interventions were implemented. According to the fall risk assessment the resident had no history of falls.

On an identified date and time, resident #005 had an un-witnessed fall and was discovered by staff on the floor in their room. A post fall assessment indicated that the cause of the fall was undetermined as the resident could not recall what they were doing prior to the fall or what may have caused them to fall. The resident sustained an identified minor injury.

Later that evening, staff discovered resident #005 on the floor of their room. The fall was not witnessed. The resident told staff that they thought they were attempting to walk to the bathroom. The resident sustained an identified minor injury.

On the following day, resident #005 was found on the floor by staff outside their bathroom door. A post fall assessment indicated that the resident was attempting to go to the washroom.

Review of the resident's clinical record indicated that after the resident's first two falls, staff had not implemented any interventions to minimize the resident's risk of falling again. Falls prevention interventions had not been implemented until after the resident had fallen for the third time at which time an identified intervention was implemented.

It was confirmed during an interview with the DOC that when the resident was reassessed and the plan of care reviewed and revised, different approaches were not considered in the revision of the plan of care until after the third fall. [s. 6. (11) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and to ensure that when a resident is reassessed and the plan of care reviewed and revised, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with r. 49(1) which requires every licensee of a long-term care home to ensure that 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.

A) A review of resident #001's clinical record indicated that they were admitted to the home on an identified date. The resident had sustained an identified quantity of falls since their admission including a fall approximately three months later that resulted in injury. The resident was assessed following this fall and determined to be a high risk for falling related to a history of prior falls.

A review of the home's policy titled, "Falls Prevention and Management" (LTC-03-06-06 with a review date of January 10, 2017), indicated the following:

Under "Procedure":

i) Refer the resident to physiotherapist or occupational therapist based on assessment, where applicable if not already on program.

Under "Appendix B-Interventions/Strategies to Reduce Risks for Falls"- High Falls Risk Must Do the following:

i) Conduct balance and strength assessments

Under "Appendix B-Interventions/Strategies to Reduce Risks for Falls"-High Falls Risk Consider:

i) Hip Protectors

An interview with the DOC confirmed that the resident was not currently on a physiotherapy program. The DOC confirmed that the resident had not been referred to the physiotherapist for any of the falls that they sustained including the most recent fall with injury. The DOC confirmed that the home does not conduct balance and strength assessments and that the home does not offer hip protectors as they are not used in the home.

The DOC confirmed that the home's Falls Prevention and Management policy had not been complied with.

B) A review of resident #005's clinical record indicated that they had no history of falls and on an identified date, a fall risk assessment indicated the resident was at moderate

risk for falls.

On a specified date, resident #005 had two falls and then a third fall the following day. A falls risk re-assessment was completed after these falls which indicated the resident was a high risk for falls.

The DOC confirmed that hip protectors were not offered as hip protectors are not used in the home. The DOC confirmed that the home's Falls Prevention and Management policy had not been complied with. (Inspector #508) [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act and is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures were developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there were none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

During stage one of the RQI, it was identified through interviews with family members that residents' identified mobility devices were not routinely cleaned by staff at the home. They had indicated that every six to twelve months a company would come in to do a thorough cleaning of the devices; however, staff at the home do not routinely clean the devices and that they had to periodically clean them while visiting.

During an interview with the DOC on an identified date, this information was confirmed. The DOC verified that procedures for cleaning specified residents' care equipment were not developed or implemented for the cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids. [s. 87. (2) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an interview with the DOC on an identified date, Long Term Care (LTC) Homes Inspectors requested a copy of the program evaluation for the Falls Prevention and Management program. During an interview the DOC confirmed that the program

evaluation for Falls Prevention had not been completed for an identified year. [s. 30. (1) 1.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A review of resident #011's Minimum Data Set (MDS) coding under section L- Oral/ dental status with an identified date, indicated that the resident was coded as having daily cleaning of their teeth by the resident or staff. A review of the corresponding narrative Resident Assessment Protocol (RAP) indicated that staff set the resident up to complete their mouth care and that at times, the resident may not be cooperative. A review of the resident's written care plan indicated under hygiene that the resident has their own teeth and that staff set the resident up for mouth care and if they are not able to complete, staff will offer assistance.

An interview with front line nursing staff #104 and 105 on an identified date indicated that staff do set the resident up for completion of their oral care needs and if the resident is unable to complete, staff will assist and if the resident refuses, they will re-attempt. The staff confirmed that oral care set up and or assistance is done twice daily for the resident. Staff confirmed that their actions are expected to be documented in the Point of Care (POC) documentation system.

A review of the POC documentation system for an identified period of seven days, indicated under the task for "Teeth/Denture care provided", that documentation had been completed once and no further documentation was included until seven days later.

An interview with the DOC confirmed that the resident was set up and or oral care was provided twice daily to the resident and that staff were to document in the POC system for these actions taken. The DOC confirmed that not all actions taken with respect to providing the resident with their oral care needs, had been documented.

B) A review of resident #003's written care plan in relation to their oral care needs indicated that the resident had their own teeth and were able to do their own mouth care with set up and cueing by staff.

An interview with front line nursing staff #104 and 105 on an identified date, indicated that the staff set up the resident twice daily for oral care and that the resident is then able

to brush their own teeth. Staff confirmed that their actions are expected to be documented in the POC documentation system.

A review of the POC documentation system for an identified period of seven days, indicated under the task for "Teeth/Denture care provided", that documentation had been completed once on four out of the seven days reviewed.

An interview with the DOC confirmed that the resident was set up and cueing was provided for oral care twice daily and that staff were to document in the POC system for these actions taken. The DOC confirmed that not all actions taken with respect to providing the resident with their oral care needs, had been documented.

C) According to the resident's written plan of care, resident #008 required set up assistance and encouragement from staff twice a day to complete oral care. During a review of the POC documentation for an identified period of time, it revealed that staff were not consistently documenting that oral care was being provided to resident #008 as specified in their plan.

It was verified during a review of the POC documentation with the DOC that the PSW staff do not always complete their documentation as required.

It was confirmed on an identified date during an interview with the DOC that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were not documented. (Inspector #508) [s. 30. (2)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written staffing plan for the nursing and personal support services program.

During a discussion with the DOC regarding how the home manages staffing shortages it was revealed that the home had a plan in place to implement in the event that they are not at full complement of PSW staff to ensure residents receive care as per their plan of care.

The DOC reviewed the plan with the Inspector; however, could not provide a written staffing plan at the time of this inspection.

It was confirmed during an interview with the DOC that there was no written staffing plan for the nursing and personal support services programs. [s. 31. (2)]

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council minutes for an identified period of approximately eight months, revealed that concerns regarding the home's inner courtyard had been documented in the minutes under a section titled, "Previous Minutes/Outstanding Business". Resident #015, a representative of the Residents' Council, wrote a letter to the licensee with these concerns which included weeds, garbage and the regular maintenance of the inner courtyard.

It was documented in the minutes that the ESM had responded to the Council; however, the minutes did not include the written response and at the time of this inspection, the Residents' Council representative could not produce a written response.

Resident #015 confirmed during an interview on an identified date, that the Council did not receive a written response regarding these concerns. It was also confirmed by the Activity and Programs lead that the licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence**

**Specifically failed to comply with the following:**

**s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).**

**Findings/Faits saillants :**

1. The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and any significant change in resident's condition, either decline or improvement, to be reassessed along with RAPs by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred.

The licensee did not comply with the conditions to which the licensee was subject for the following identified resident:

A review of resident #014’s clinical record indicated that the resident had a significant decline in their health and identified care measures were implemented on an identified date.

A review of the MDS indicated that an annual MDS assessment was completed on an identified date. No further MDS assessments were completed after this date when the resident had a significant change in their health status.

It was confirmed by the DOC on an identified date, that the home did not complete a significant change in status assessment when the resident had a significant decline in their health status. [s. 101. (4)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply**
**Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:**
**1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
**2. Access to these areas shall be restricted to,**
**i. persons who may dispense, prescribe or administer drugs in the home, and**
**ii. the Administrator.**
**3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following: 2. Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On an identified date, it was observed and confirmed by the DOC that drugs were stored for drug destruction in the office of the DOC. The DOC confirmed that both the CEO and the DOC had access to this area along with other managers in the home who may not dispense, prescribe or administer drugs in the home. The DOC confirmed that the home had not ensured that areas where drugs were stored were restricted only to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home's "Medication Incident Report" forms from May 2016 until May 2017, indicated the following:

A) On an identified date and time, resident #012's medications were not administered but documented on the Medication Administration Record (MAR) that they had been administered. The DOC confirmed that this incident had not been reported to the resident's substitute decision-maker (SDM) and pharmacy service provider.

B) On an identified date, resident #013 was administered the wrong medications. The DOC confirmed that this incident had not been reported to the pharmacy service provider. [s. 135. (1)]

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**Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée**

**Issued on this 12th day of July, 2017**

**Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs**

**Original report signed by the inspector.**