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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 13, 2018	2018_704682_0008	004771-18	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

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

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

AILEEN GRABA (682), KELLY CHUCKRY (611), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 7, 8, 9, 12, 13, 14, 15, 2018.

This Resident Quality Inspection (RQI) was done concurrently with the following inquiry: 024141-17 related to nutrition.

This Resident Quality Inspection (RQI) was done concurrently with the following Critical Incident System (CIS) intake: 015996-17 related to fall prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Registered Dietician (RD), Registered staff, Personal Support Workers (PSW), Administrator Assistant- Finance, Activation Therapist, President of Resident Council, Family Council Chair, residents and families.

During the course of this inspection, the inspectors observed the provision of care and reviewed clinical health records, investigation notes, meeting minutes, policy and procedures, committee meeting minutes, quality improvement data sheets, education material and medication incident reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Quality Improvement
Residents' Council
Skin and Wound Care

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

- **7 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

According to the home's medication incident documentation system and resident #004's health records they were administered resident #007's medications instead of their own at an identified time on an identified date in 2018. Registered staff #109 confused residents #004 and #007's medications. The physician was contacted and instructed staff to closely monitor resident #004's for any changes in health condition. Both registered staff #103 and the Director of Resident Care confirmed that resident #004 had been administered medications that had not been prescribed to them. [s. 131. (1)]

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A) According to the home's medication incident documentation system and resident #008's health records, resident #008 was prescribed medication to be administered each morning and each evening. However, during the evening on an identified date in 2017, they received medication not as prescribed. The physician was notified. During interview, the Director of Resident Care confirmed that resident #008 received medication that had not been prescribed for administration at that time. (Inspector 526)

B) According to the home's medication incident documentation system, resident #003 was not administered medications on an identified date in 2017 as prescribed. The

incident report and interview with the Director of Resident Care (DRC) indicated that staff reported that the medications were found the following day at the bedside and had not been administered. During interview, the DRC confirmed that resident #003 had not had medications administered in accordance with the directions for use specified by the prescriber. (Inspector 526)

C) Resident #006 was prescribed an analgesic to be administered at a specified time and staff were to monitor the administration and document on each shift. According to a medication incident report, registered staff had documented their assessment on an identified date in 2017. Registered staff #102 went to administer the prescribed analgesic on their shift at an identified time but could not verify that the previous dose was administered as prescribed. Registered #102 stated that since the medication administration could not be confirmed, the resident had gone without the prescribed analgesic for an unknown period of time when it was last confirmed for resident #006. Therefore resident #006 had not received the medication as prescribed. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (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. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to

the resident as specified in the plan.

A clinical record review indicated that resident #002 had a repositioning schedule posted above their bed and was to be transferred back to bed at an identified time daily. Observations of the resident on an identified date in 2018, indicated that resident continued to sit in their wheelchair and was not returned to bed as per the plan of care. During an interview on an identified date in 2018, staff #108 stated that resident was not transferred at the identified time and that they were not aware of why resident #002 was not transferred back to bed as per schedule. During an interview on a identified date in 2018, the DRC stated that resident #002 was not transferred back to bed as per repositioning schedule and that the home failed to ensure that the care set out in the plan of care regarding repositioning was provided to resident #002 as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary

A) Resident #005 was admitted to the home on an identified date in 2016 at which time they were assessed for continence. They required a medical procedure on a identified date in 2017, and returned to the home with a medical intervention. Review of the document the home referred to as the care plan dated March 11, 2018, indicated the resident had the medical intervention to promote skin integrity. Registered staff #106 stated that the resident did not have any issues with skin integrity at the time of this inspection. The resident had undergone an additional medical procedure on an identified date in 2017, however their continence status and continued need for the medical intervention on an identified date in 2018, was not reassessed. (Inspector 526)

B) Review of resident #013's health record indicated that they had been admitted to the home on an identified date in 2011 and at that time they were incontinent. They had a medical intervention on an identified date in 2011 in relation to the promotion of skin integrity. Review of their most recent RAI MDS completed on an identified date in 2018 indicated that the resident continued to have a medical intervention but no longer had an issue with skin integrity. During interview, the DRC stated that the resident had not been reassessed when their care needs changed. The DRC confirmed that the resident had not had a continence assessment using a clinically appropriate instrument designed for that purpose since admission. The home's "Continence Care" policy number LTC-08-22-02 reviewed January 2018 directed staff to reassess each resident's bowel and bladder

function when there was any change in the resident's health status.

During interview, the DRC confirmed that residents only received bladder and bowel assessments on admission to the home. The DRC also confirmed that a continence assessment had not been completed when resident #005's care needs changed and the plan of care was not reviewed and revised in relation to continence. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan and; to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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. With respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 under O. Reg 79/10, the licensee failed to ensure that the home's continence care and bowel management program was evaluated and updated at least annually in accordance with evidence based practices and, if there were none, in accordance with prevailing practices.

Review of the home's Professional Advisory Committee meeting minutes dated January 25, 2018, indicated that there had been no annual evaluation of the home's continence

care and bowel management program. During interview, the Director of Resident Care stated that no annual program evaluations had been completed for 2017 according to evidence based practices or prevailing practices. [s. 30. (1) 3.]

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.

The licensee failed to ensure that assessments related to significant weight changes and altered skin integrity for residents #002 and #003 completed by the Registered Dietitian were documented.

A) A clinical record review indicated that on an identified date in 2018, resident's #002 weight was documented as a change of 7.5 per cent (%) of body weight or more over three months as well as a change of 10% of body weight, or more over 6 months. Subsequently on an identified date in 2018, the resident's weight was documented as a change of 7.5% of body weight or more over three months as well as a change of 10% of body weight, or more over 6 months. On an identified date in 2018, the resident's weight continued to indicate a change of 10% of body weight, or more, over 6 months. During an interview, the RD stated that they were aware and reassessed the resident in regards to the weight changes in 2018. The RD stated that they failed to document their reassessment, actions and the resident's responses to interventions with regards to weight changes and documented only at the quarterly review. (Inspector 682)

B) A clinical record review indicated that dietary referrals were completed for new skin breakdown for resident #002 on identified dates in 2018. During an interview, registered staff #106 stated that dietary referrals were left for the RD to review weekly. During an interview, the RD stated that they assessed resident #002 for altered skin integrity. The RD stated that they failed to document their reassessment, actions and resident's #002 responses to interventions with regards to the new skin breakdown in 2018 and only documented within the quarterly review. (Inspector 682)

C) A clinical record review indicated that a dietary referral was completed for new skin breakdown for resident #003 on an identified date in 2018. On an identified date in 2018, an interview with the RD identified that they assessed the resident for altered skin integrity on an unidentified date. The RD stated that they did not document unless there were changes to the dietary interventions in relation to the referral for new skin breakdown. The RD stated they failed to document their reassessment, actions and

resident responses to interventions with regards to the new skin breakdown. [s. 30. (2)]

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 the home's continence care and bowel management program are evaluated and updated at least annually in accordance with evidence based practices and, if there were none, in accordance with prevailing practices and; 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 are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A) Review of resident #012's resident assessment instrument - minimum data set (RAI-MDS) assessment completed on an identified date in 2018, indicated that they had a deterioration in continence compared to the previous RAI MDS assessment on an identified date in 2017. Review of their health records and interview with the DRC confirmed that resident #012 had not had a continence assessment using a clinically appropriate instrument designed for that purpose when their continence worsened. [s. 51. (2) (a)]

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 the resident who was incontinent receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the effectiveness of the home's medication management system was evaluated quarterly and that the interdisciplinary team that met included the Administrator and the Medical Director.

Review of the home's Professional Advisory Committee Meeting minutes dated March 23 and October 12, 2017, and January 25, 2018, indicated that the home's medication management system was reviewed only twice during 2017, and once in 2018. The attendees to these meetings did not include the Medical Director or the Administrator. This was confirmed by the Director of Resident Care. [s. 115. (1)]

2. The licensee failed to ensure that the quarterly evaluations of the medication management system included a review of medication incidents as referred to in sections 135(2) and (3) so that the changes and improvements identified in the review were implemented and a written record was kept.

Review of the home's Health Care Advisory Committee (HCAC) meeting minutes dated October 12, 2017, and January 25, 2018, indicated that types of medication incidents were listed, that the incidents had been addressed and that there were no adverse effects to residents. There was no documentation or indication that medication incidents were analyzed, or changes and improvements discussed during the HCAC meetings, or upon review of the home's Medication Safety Meeting held on January 22, 2108. This was confirmed by the Director of Resident Care (DRC) during interview on an identified date in 2018. [s. 115. (3)]

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 the effectiveness of the home's medication management system is evaluated quarterly and that the interdisciplinary team that meet include the Administrator and the Medical Director and; to ensure that the quarterly evaluations of the medication management system include a review of medication incidents as referred to in sections 135(2) and (3) so that the changes and improvements identified in the review are implemented and a written record is kept, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, and a Registered Dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, that include a review of the quarterly evaluations in the previous year as referred to in section 115, and changes identified to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the home's medication management program documentation, and Professional Advisory Committee meeting minutes indicated that the Administrator, Medical Director, and Registered Dietitian did not participate in annual evaluations of the effectiveness of the medication management system in the home or to recommend any changes necessary to improve the system.

Furthermore, the annual evaluation did not include a review of the quarterly evaluations in the previous year as referred to in section 115, and did not identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. This was confirmed by the Director of Resident Care on an identified date in 2018. [s. 116. (1)]

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 an interdisciplinary team, which includes the Medical Director, the Administrator, and a Registered Dietitian who is a member of the staff of the home, meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #7: 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 was documented together with a record of the immediate actions taken to assess and maintain the resident's health, and that it was reported to the resident, the resident's SDM, 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 and that all medication incidents were documented, reviewed and analyzed, corrective action was taken and that a written record was kept.

A) According to the home's medication incident documentation system, on an identified

date in 2017, registered staff #102 could not confirm resident #006's analgesic administration when they went to administer a subsequent dose. During interview, registered staff #102 stated that they felt that there was no negative impact to the resident. Review of progress notes indicated that the incident was not documented and there was no note that the physician was notified or that the resident was assessed. Review of incident documentation and the electronic medication record indicated that the analgesic administration had been confirmed by registered staff on an identified date in 2017. Review of progress notes indicated that the incident was not documented and there was no note that the physician was notified or that the resident was assessed. (Inspector 526)

B) According to the home's medication incident documentation system, on an identified date in 2017, resident #009's previous evening's medications were found by registered staff at their bedside. A medication incident report was completed that indicated that the evening shift registered staff did not complete the medication administration. Review of progress notes indicated that the missed medication had not been documented with immediate actions taken to assess and maintain the resident's health, and the medication error had not been reported to the resident's SDM, the Medical Director who was the prescriber of the drug and the resident's attending physician or a registered nurse in the extended class attending the resident. (Inspector 526)

C) According to the home's medication incident documentation system, on an identified date in 2018, resident #004 received resident #007's medications at an identified time. Review of resident #004's health records and the incident report indicated that the physician was contacted However, there was no indication if the resident's substitute decision maker was contacted, that the incident was reviewed and analyzed and if corrective action was taken. This was confirmed by the home's Director of Resident Care. The DRC confirmed that not all medication incidents in the home were documented with a record of the immediate actions taken to assess and maintain the resident's health, reported to the resident, their substitute decision maker, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident. The DRC also confirmed that there was not a written record of review, analysis, or corrective action of all medication incidents. (Inspector 526)

D) The Medical Pharmacies "Medication Incident Reporting" policy number 9-1, dated February 2017, that was in place at the time of this inspection indicated that a medication incident was defined as any preventable event that may cause or lead to inappropriate

medication use or client harm while the medication was in control of the health care professional, client or consumer. A "near miss" was defined as an incident that could have led to harm however the resident did not receive the medication; all near miss incidents were under the "no harm" category of the reporting system. The Home's "Medication Incident" policy number LTC-09-02-03, dated August 2017, indicated that if any medication incident was to be reported by calling or by using the online reporting system. An incident was a "near miss" that did not affect a resident, and a medication incident report still needed to be completed using the home's electronic medication incident reporting system.

During interview, staff #105 reported that they observed two medication cups on the table and residents #010 and #011 told registered staff #102 that they thought that their medications had been mixed up and that they were given each other's. According to staff #105, registered staff #102 moved the medication cups so that they were in front of the desired resident, and went back to administering medications to other residents. During interview, resident #010 reported that they recalled when registered staff #102 mixed up theirs' and resident's #011 medications.

During interview, registered staff #102 stated they had poured medications for residents #010 and #011 at the same time on an unidentified day and mistakenly mixed the medications up when placing them on the table in front of the residents. Then the residents reported the mixed up and the staff placed them in front of the right residents. The registered staff also stated that they did not report the incident to the DRC, or document it using the home's electronic incident reporting system. Registered staff #102 stated that they did not think "near misses" were medication incidents and did not report any to the DRC or document them.

During interview, the DRC stated that near miss incidents were considered medication incidents according to the home's policy, but that staff did not always report these to them or document them using the home's incident reporting system. The DRC also stated that they did not review, analyze, document or track near miss medication incidents. [s. 135. (1)]

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 every medication incident involving a resident is documented together with a record of the immediate actions taken to assess and maintain the resident's health, and that it is reported to the resident, the resident's SDM, 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 and that all medication incidents are documented, reviewed and analyzed, corrective action is taken and that a written record is kept, to be implemented voluntarily.

Issued on this 30th day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AILEEN GRABA (682), KELLY CHUCKRY (611), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2018_704682_0008
Log No. / No de registre :	004771-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 13, 2018
Licensee / Titulaire de permis :	Niagara Ina Grafton Gage Village 413 Linwell Road, St. Catharines, ON, L2M-7Y2
LTC Home / Foyer de SLD :	Niagara Ina Grafton Gage Village 413 Linwell Road, St. Catharines, ON, L2M-7Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick O'Neill

To Niagara Ina Grafton Gage Village, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131(2) of Ontario Regulation 79/10.

Specifically the licensee must:

a) Ensure residents #003, #006, #008 and any other residents, are administered drugs in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A) According to the home's medication incident documentation system and resident #008's health records, resident #008 was prescribed medication to be administered each morning and each evening. However, during the evening on an identified date in 2017, they received medication not as prescribed. The physician was notified. During interview, the Director of Resident Care confirmed that resident #008 received medication that had not been prescribed for administration at that time. (Inspector 526)

B) According to the home's medication incident documentation system, resident #003 was not administered medications on an identified date in 2017 as prescribed. The incident report and interview with the Director of Resident Care (DRC) indicated that staff reported that the medications were found the following day at the bedside and had not been administered. During interview, the DRC confirmed that resident #003 had not had medications administered in accordance with the directions for use specified by the prescriber. (Inspector 526)

C) Resident #006 was prescribed an analgesic to be administered at a specified time and staff were to monitor the administration and document on each shift. According to a medication incident report, registered staff had documented their assessment on an identified date in 2017. Registered staff #102 went to administer the prescribed analgesic on their shift at an identified time but could not verify that the previous dose was administered as prescribed. Registered #102 stated that since the medication administration could not be confirmed, the resident had gone without the prescribed analgesic for an unknown period of time when it was last confirmed for resident #006. Therefore resident #006 had not received the medication as prescribed. [s. 131. (2)]

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 2 as it related to three of four residents reviewed. The home had a level 3 compliance history as they had previous non-compliance in a similar area that included:
~ s. 130. 2. written notification (WN) issued May 25, 2017 (2017_575214_0008);
~ s. 135. (1) written notification (WN) issued May 25, 2017 (2017_575214_0008);
~ s. 129. (1) (a) voluntary plan of correction (VPC) issued issued May 3, 2016 (2016_248214_0009);
~ s. 129. (1) (b) voluntary plan of correction (VPC) issued issued May 3, 2016 (2016_248214_0009). (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Aileen Graba

Service Area Office / Bureau régional de services : Hamilton Service Area Office