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
May 15, 2018	2018_704682_0011	022287-17	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 1, 2, 3, 4, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Registered staff, Personal Support Workers (PSW), Administrator Assistant- Finance, residents and families.

During the course of this inspection, the inspector observed the provision of care and reviewed clinical health records, investigation notes, complaints and concerns binder, policy and procedures, education material and training records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 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 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. (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 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).

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 #001 had an intervention that was used as a deterrent to prevent specified responsive behaviours. Observations on an identified date in 2018 revealed that the intervention was not in place as per resident's #001 plan of care. During an interview, staff #104 stated that it should be in place. Further observation on an identified date revealed that the intervention was again not in place as per resident's plan of care. Staff #104 stated again that the intervention should be in place. During an interview the DRC stated that home failed to ensure that the care set out in the plan of care was provided to resident #001 as per the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that different approaches are considered in the revision of the plan of care when the care set out in the plan has not been effective. 2007, c. 8, s. 6 (11)

A clinical record review indicated that over a three month period in 2018, there had been 11 recorded occasions where the resident demonstrated responsive behaviours which posed a risk to themselves or co-residents.

During interview, registered staff #103, #105 and #109 and staff #104, #106 and #107 stated resident #002 continued demonstrating responsive behaviours despite the current plan of care/interventions. During an interview the DRC stated that an approach initiated on an identified date in 2016 for resident #002 was not effective. The DRC also stated that resident #002 was not referred to specialized resources. The DRC also confirmed that the home failed to ensure that different approaches were considered when the care set out in the plan related to behaviour was not effective. [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 the care set out in the plan of care is provided to the resident as specified in the plan; to ensure that different approaches are considered in the revision of the plan of care when the care set out in the plan is not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches are developed to meet the needs of the residents with responsive behaviours that include: screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

According to the plan of care, resident #002 had a known history of responsive behaviours. Progress notes reviewed over a three month period in 2018, revealed 11 recorded occasions where the resident demonstrated responsive behaviours which posed a risk to themselves or co-residents.

A review of the written plan of care, in 2018, revealed interventions had been implemented to manage responsive behaviours.

During an interview, registered staff #103, #105 and #109 and staff #104, #106 and #107 stated that the interventions had not effectively managed the responsive behaviours. The DRC stated in an interview that resident #002 was not referred to specialized services. The DRC also confirmed the home had not developed nor implemented written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, resident monitoring and internal reporting protocols and protocols for the referral of residents to specialized resources where required. [s. 53. (1) 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 written approaches are developed to meet the needs of the residents with responsive behaviours that include: screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, 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. (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 has 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 are documented.

The licensee failed to ensure that interventions related to responsive behaviours for resident #002 completed by registered staff, were documented.

A clinical record review indicated that resident's #002 plan of care included an intervention initiated on an identified date in 2016 to prevent responsive behaviours. During an interview, registered staff #105 indicated that the intervention was documented on a form by registered staff. Further clinical record review revealed that there were missing signatures on identified dates over a two month period in 2018. Registered staff #103 and #105 stated that they forgot to document the intervention. During an interview, the DRC stated that the home failed to ensure that interventions for resident #002 were documented. [s. 30. (2)]

Issued on this 23rd day of May, 2018

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

Original report signed by the inspector.