Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 23, 2021	2021_905683_0010	025667-20, 000196-21, 006146-21	Complaint

Licensee/Titulaire de permis

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

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

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

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

LISA BOS (683)

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): July 9, 12, 15, 16, 19 and 20, 2021.

This inspection was completed concurrently with critical incident inspection #2021_905683_0011.

The following intakes were completed during this complaint inspection:
Log #025667-20 was related to skin and wound, personal support services and continence care and bowel management;
Log #000196-21 was related to maintenance, skin and wound, personal support services and continence care and bowel management; and
Log #006146-21 was related to maintenance, skin and wound, personal support services and continence care and bowel management.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Resident Care (DRC), the Manager of Environmental Services, the Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, resident and staff interactions, infection prevention and control practices and reviewed clinical health records, relevant policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Safe and Secure Home
Skin and Wound Care

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

4 WN(s)
1 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	Légende 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. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Registered Dietitian (RD) who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The RD was responsible for nutrition assessments for all residents in the home. They reported that the they had not been on site in the home since the start of the COVID-19 pandemic, and had been completing all assessments by reviewing the available documentation in Point Click Care (PCC) and through telephone conversations with registered staff. They reported that registered staff called them with any nutrition referrals, or they would find them through review of resident progress notes.

The Director of Resident Care (DRC) was aware of the arrangement. They reported that referrals were made to the RD on a paper form or staff would call them. Skin and wound assessments were documented on a paper form, which the RD was not able to access offsite, and for any paper referrals, the RD had to call in.

By not being onsite to complete clinical and nutrition care duties, the RD did not have direct access to all available information including RD referrals, complete skin assessments and resident observations in order to complete a comprehensive nutritional assessment, which increased the risk that appropriate nutrition interventions would not be implemented.

Sources: Nutrition referrals; interviews with the RD and DRC. [s. 74. (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 a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing at a minimum in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home, and that the temperature was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home was unable to provide the Inspector a copy of their air temperature records upon request. The DRC acknowledged that they were unaware of the requirements for air temperature monitoring and acknowledged that temperatures were not being monitored in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home, three times a day.

Sources: Interview with the DRC [s. 21. (2) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was assessed by a RD who was a member of the staff of the home when they exhibited a new area of impaired skin integrity.

A resident had a history of impaired skin integrity. A progress note by a Registered Nurse (RN) indicated that they developed a new area of impaired skin integrity and they documented that a referral was not sent to the RD. Further review of the resident's clinical record did not identify any assessments by the RD until two months later.

The DRC reported that there was a paper referral form for the RD to indicate all new areas of impaired skin integrity. Upon review of the resident's clinical record, there were no referrals to the RD for the resident's new area of impaired skin integrity.

A Registered Practical Nurse (RPN) indicated that they did not refer to the RD because the wound care nurse was responsible for the referrals. In an interview with wound care nurse, they were unable to identify why a referral was not sent to the RD for the resident's new area of impaired skin integrity and acknowledged that one should have been sent.

The RD reported that they had not been working onsite in the home, but staff would call them with referrals, or they would identify residents requiring nutrition assessment based on a review of their electronic records. They acknowledged that they were not aware of the resident's new area of impaired skin integrity. They reported that they typically responded to referrals within one week.

There was no referral to the RD for a resident's new area of impaired skin integrity, thus, no assessment by the RD, which put the resident at risk for not receiving appropriate nutrition intervention to promote wound healing.

Sources: A resident's clinical record; interviews with a RPN, the wound care nurse, the DRC and the RD. [s. 50. (2) (b) (iii)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Physician attended regularly at the home to provide services, including assessments.

A complaint was received regarding a Physician not attending the home during the COVID-19 pandemic.

The DRC confirmed that a Physician was the sole Physician providing medical care to a resident and acknowledged that they had not entered the home to provide medical services, including assessments, for approximately 11 months. They indicated that although the Physician had not been in the home, there was active communication with them and the resident's family, with respect to the resident's health status.

A review of the progress notes for a resident included several notes by registered staff that the Physician would try to come in and see the resident as soon as possible, but there was no documentation in the resident's clinical record that the Physician entered the home to complete their assessments.

The DRC confirmed that they were aware the resident's Physician had not entered the home for an extended period and a documented plan for how medical services would be provided to the resident under these circumstances was not in place.

Not having a resident's Physician attend the home regularly to assess the resident increased the risk that medical situations and conditions presented by the resident would go undiagnosed and not managed.

Sources: A resident's clinical record; interview with the DRC. [s. 82. (1) (b)]

Issued on this 23rd day of July, 2021

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

Original report signed by the inspector.