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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 6, 2022
Inspection Number 2022_1493_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Niagara Ina Grafton Gage Village

Long-Term Care Home and City
Niagara Ina Grafton Gage Village, St. Catharines

Lead Inspector
Lisa Bos (683)

Additional Inspector(s)
Daria Trzos (561)

Jobby James
Digitally signed by Jobby James
Date: 2022.08.11 14:10:35 -04'00'
Inspector Digital Signature

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 5-6, 9-13, 2022

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) (c)

The licensee has failed to ensure that a resident's plan of care provided clear direction to staff related to the type of sling the resident required during transfer.

Rationale and Summary
A resident was observed with a sling under them. Their written plan of care under the toileting section indicated that staff were to use a specific sized sling while transferring, and under the transfer section, it stated to use a different sized sling for transfers. Personal Support Worker (PSW) and registered staff were interviewed and confirmed that the resident required a specific sling size for all transfers and that the written plan of care did not provide clear direction to staff. The written plan of care was revised the following day with the correct information.

There was no impact and no risk to the resident as staff were using the correct sling at the time of the observation.

Date Remedy Implemented: May 18, 2022 [561]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

Rationale and Summary
A resident was assessed by the Registered Dietitian (RD) to be at high nutritional risk. Their written plan of care indicated that they were at moderate nutritional risk. The RD acknowledged that the resident's care plan should have been updated to reflect that they were at a high nutritional risk.

The RD immediately updated the resident's care plan to indicate that they were at high nutritional risk. There was no impact and no risk to the resident as other areas of their clinical record indicated that they were at high nutritional risk.

Date Remedy Implemented: May 10, 2022 [683]

NC#03 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 85 (3) (a)

The licensee has failed to ensure that the revised Residents' Bill of Rights was posted in the home.

Rationale and Summary
During the initial tour of the home, it was observed that the old version of Residents' Bill of Rights under the Long-Term Care Homes Act 2010, was posted in the home. The Director of Resident Care (DRC) was not aware that the Residents' Bill of Rights was revised under the Fixing Long-Term Care Act (FLTCA), 2021. The new version was then posted in the home.

Date Remedy Implemented: May 16, 2022 [561]

NC#04 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 11 (1) (b)

The licensee has failed to ensure that their procedure for the monitoring of food temperatures was complied with.

Rationale and Summary
FLTCA s. 15 (1) (a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

O. Reg. 246/22, s. 79 (1) 5 requires that food and fluids are served at a temperature that is both safe and palatable to the residents.

Specifically, staff did not comply with the home's Food Temperatures Recording Chart, which was part of the home's nutrition care and dietary services program. The procedure indicated that staff were to take temperatures in the production and servery areas.

Documentation of food temperatures for the breakfast and lunch meals was reviewed for one occasion and food temperatures were recorded in the servery, but not in the production area.

The Interim Food Service Manager (FSM) stated that the cooks took the temperatures but did not document them. They immediately requested that the cooks document the food temperatures on the Food Temperature Recording Chart for the next meal service and provided documentation to support compliance.

There was no impact or low risk to residents as the Interim FSM reported all food went directly from the ovens to the servery area and all temperatures taken in the servery reached safe internal temperatures.

Date Remedy Implemented: May 7, 2022 [683]

NC#05 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 79 (1) 1.

The licensee has failed to ensure that the daily menu was communicated to residents.

Rationale and Summary
During a dining observation, it was noted that the daily menu was not posted in the home. The Interim FSM acknowledged that the daily menu was not posted in the home and that it was not communicated to all residents.

The Interim FSM posted the daily menu outside of the dining room. There was no impact or low risk to the residents as the weekly menu was posted and residents who ate in their room received a copy of the daily menu.

Date Remedy Implemented: May 6, 2022 [683]

NC#06 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
i. s. 9.1 of the IPAC Standard for Long-Term Care Homes, indicates that additional precautions shall include point-of-care signage indicating that enhanced IPAC measures are in place.

During observations, Airborne/Droplet/Contact precautions signage was posted on the door to a resident room. Registered staff were observed entering the room without an N95 mask. The Director of Resident Care (DRC) stated that the resident was not on Airborne precautions. The signage was removed, and the appropriate Droplet/Contact precautions signage was posted on May 6, 2022. There was no impact to the resident as the staff were wearing appropriate PPE, the additional precautions signage that was posted was incorrect.

Date Remedy Implemented: May 6, 2022 [561]

ii. A resident had signage outside their door indicating that they were on Droplet/Contact precautions. Two individuals were observed exiting the resident's room, and they were not wearing appropriate PPE for Droplet/Contact precautions.

The DRC reported that the resident was on Contact precautions, and that Droplet precautions were not required.

The signage on the resident's door was updated accordingly. There was no impact or low risk as the signage was more than required based on the resident's diagnosis, and the individuals were wearing appropriate PPE for a resident in Contact precautions.

Date Remedy Implemented: May 16, 2022 [683]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 43 (4)

The licensee has failed to ensure that the advice of the Residents' Council was sought in carrying out the resident and family/caregiver experience survey.

Rationale and Summary
The Residents' Council meeting minutes were reviewed and there was no documentation to support that the Council's advice was sought out in carrying out the resident and family/caregiver experience survey.

The DRC acknowledged that the home did not seek the advice of the Residents' Council in carrying out survey, but their advice was used based on complaints and their meeting minutes. They acknowledged that the Council was not aware that their meeting minutes were being used to create the surveys, and the Council was not provided the opportunity to review the survey questions prior to it going out.

Sources: Residents' Council meeting minutes; interview with the DRC and other staff [683]

WRITTEN NOTIFICATION: FAMILY COUNCIL

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 65 (7) (b)

The licensee has failed to ensure that semi-annual meetings were convened to advise residents' families and persons of importance to residents of the right to establish a Family Council.

Rationale and Summary
The DRC and Activation Therapist reported that once a year, a letter was sent to families of residents to advise them of their right to establish a Family Council. The DRC stated that the practice of semi-annual meetings was not sustained because of the COVID-19 pandemic, but a letter was sent to families in May 2022, to advise them of their right to establish a Family Council. There was no further documentation to support that families were advised on a semi-annual basis of their right to establish a council.

Sources: Letter sent to families dated May 2022; interview with the Activation Therapist and the DRC [683]

WRITTEN NOTIFICATION: POLICIES, ETC., TO BE FOLLOWED

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 11 (1) (b)

The licensee has failed to ensure that their Head Injury Routine policy was complied with.

Rationale and Summary

In Accordance with O. Reg. 246/22, s. 53 (1) 1, and in reference to O. Reg. 246/22, s. 34 (1) 1., the home was required to have a written description of the falls prevention and management program that included relevant policies to reduce risk and monitor outcomes.

Specifically, staff did not comply with the home's Head Injury Routine (HIR) policy which indicated that neuro vital signs should be monitored after a head injury on a neuro vital signs form. The definition of a head injury included a resident who had a fall, and due to cognitive deficits was unable to confirm or deny hitting their head.

A resident sustained an unwitnessed fall. A review of their clinical record did not identify a HIR assessment completed for their fall.

The DRC acknowledged that the resident was not cognitive and that HIR should have been completed after their fall, according to their HIR policy.

There was risk that changes in neuro vital signs may have gone unnoticed when staff did not complete a HIR assessment as per the home's policy.

Sources: A resident's clinical record; interview with the DRC and other staff [683]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC#10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 34 (2)

A. The licensee has failed to ensure that any actions taken with respect to residents under the dietary services and hydration program, as required in FLTCA s. 15 (1) were documented.

Rationale and Summary

Two residents were at high nutritional risk. Their written plans of care directed staff to document the amount of food and fluid taken at each meal.

The residents were observed eating lunch. The Point of Care (POC) records were reviewed for the lunch meal and there was no documentation of the their food and fluid intake.

The DRC reported that food and fluid intake was documented in POC and acknowledged that there was no documentation of the food and fluid intake for either resident for the lunch meal that was observed.

Sources: Resident clinical records; observation of the lunch meal; interview with the DRC [683]

B. The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound care program, as required in O. Reg. 246/22 s. 53 (1) 2 were documented.

Rationale and Summary
A resident's clinical record indicated that they had several areas of impaired skin integrity. Their electronic Treatment Administration Record (eTAR) directed staff to assess the wounds every week, using the Stage Two Wound Assessment tool.

A review of the Stage Two Wound Assessment tool for each of the resident's wounds identified that the wounds were not assessed for a period of ten days.

A Registered Nurse (RN) reported that they completed the resident's skin assessments as required, but they did not document their assessments.

Sources: A resident's clinical record; Stage two wound assessment tool, care plan and treatment form; interview with a RN and other staff [683]

C. The licensee has failed to ensure that provision of care related to bathing was documented for a resident.

Rationale and Summary
A resident's clinical record was reviewed for a period of one month. On one occasion, there was no documentation that the resident received their scheduled bath. A PSW stated that the resident refused to be bathed. It was an expectation that the provision of care was documented in POC; however, they forgot to do so that day**.**

Sources: A resident's clinical records; interview with a resident and staff [561]

WRITTEN NOTIFICATION: BATHING

NC#11 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 37 (1)

The licensee has failed to ensure that a resident was bathed by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition

Rationale and Summary
A resident indicated that their preferred choice for bathing was a shower, however, the staff provided them with a bath. The resident's written plan of care indicated that they preferred a bath. A PSW stated that the shower room was too small and was not being used for showers. They stated that none of the residents in the home were being provided with a choice of a shower due to the shower room not being functional. This was also confirmed by the DRC.

Not providing a preference for bathing may have contributed to the resident refusing to bathe and increased the risk for having poor hygiene.

Sources: A resident's written plan of care; observations of the shower room; interview with a resident and staff. [561]

WRITTEN NOTIFICATION: FOOT CARE AND NAIL CARE

NC#12 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 39 (1) under FLTCA and s. 35 (1) of the O. Reg. 79/10 under LTCHA, 2007

The licensee has failed to ensure that three residents received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 35(1) of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 39(1) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary
In an interview with family members and PSW staff in the home, it was identified that the home did not provide basic foot care services, including the cutting of toenails without having to pay for this service. The DRC indicated that three residents opted out to pay for basic foot care and therefore, their families were responsible to cut and trim the residents' toenails. The home did not have appropriate equipment to cut and trim toenails.

The home's Foot Care policy indicated that the basic and advanced foot care would be provided to residents by a RPN that had a certificate in basic and advanced foot care. This care would be provided on an additional pay for service basis.

Sources: List of residents that pay for basic foot care; the home's Foot Care policy; interviews with family members, staff, and the DRC [561]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC#13 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident during transfer.

Rationale and Summary
An inspector observed two PSWs porter resident down the hallway in a lift. The two PSWs indicated that this was the method they used to porter residents from the tub room to their rooms. The home's Minimal/Zero Lift Policy stated that the caregiver needed to ensure the client was transferred the shortest distance possible. The DRC confirmed that portering residents in a lift was not safe and it was not the home's practice.

Portering the resident in a lift increased the risk for injury and safety of the resident.

Sources: Observations; the home's Minimal/Zero Lift Policy; interviews with staff [561]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC#14 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s*. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's wound was reassessed weekly by a member of the registered nursing staff.

Rationale and Summary
A resident's eTAR directed staff to assess a wound weekly using the Stage Two Wound Assessment tool.

A RN documented on the Stage Two Wound Assessment tool that the dressing was dry and intact. There was no documentation of the size of the wound, appearance of underlying tissue, exudate, etc., as required on the assessment tool. The wound was not assessed for twelve days and increased in size from the previous assessment.

A RN acknowledged that they did not complete an assessment of the resident's wound, because it was a new dressing, and they did not want to remove it.

Sources: A resident's eTAR; Stage Two Wound Assessment tool; Interview with a RN and other staff [683]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC#15 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (4) (c)

The licensee has failed to ensure that the interdisciplinary IPAC team met at least quarterly.

Rationale and Summary
The DRC acknowledged that the interdisciplinary IPAC team did not meet within the past quarter and there were no records to support that a meeting occurred.

Sources: Interview with the DRC [683]

NC#16 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (4) (e)

The licensee has failed to ensure that the IPAC program was evaluated and updated at least annually in accordance with the standards and protocols issued by the Director.

Rationale and Summary
The DRC acknowledged that there was not an annual evaluation of the home's IPAC program within the past year, as previous management had concerns about allowing external visitors into the facility, which impacted Professional Advisory Committee (PAC) meetings and evaluation.

Sources: Interview with the DRC; email from the DRC [683]

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC#17 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 123 (3) a

The licensee has failed to ensure that written policies as indicated in O. Reg 246/22, s.123 (2) that must be developed for the medication management system to ensure the accurate destruction and disposal of all drugs used in the home, were implemented in the home.

Rationale and Summary
The home's Drug Destruction and Disposal policy stated that monitored medications awaiting destruction were to be removed and retained in the double-locked wooden box, in the locked medication room, separate from medications available for administration to a resident. Two nurses were to document the required information on the Count Sheet and on the Drug

Destruction and Disposal Monitored Substance log when the medication was removed from the active orders in the cart and placed into a wooden box. The Individual Monitored Medication Record was to be attached to the medications being placed in the wooden box to allow for verification of the amount to be destroyed.

i. A Registered Practical Nurse (RPN) indicated that narcotics that were discontinued on the weekend were kept in the medication cart along with narcotics available for administration to residents until the DRC came to work on Monday after the weekend. The DRC explained the process of narcotics destruction in the home and confirmed that if a narcotic was being discontinued or needed to be removed from administration, the registered staff were to keep it in the narcotic bin in the medication cart until they were available to remove it from there. The destruction wooden box was in the DRC's office, and they were the ones that had access to it.

ii. The DRC showed a grey metal locked box attached to the wall in the medication room. The DRC stated that narcotics awaiting destruction could be placed there when the DRC was not available during the weekend. When the Inspector asked the DRC to unlock the box, they found several narcotics inside that did not have proper labels, and there was no individual monitored medication record attached. A few of the medications were wrapped in tissue, one was unmarked and unlabelled and one was in a small Ziploc bag. A RPN stated that the box had not been used for some time and they were previously told not to use it. The DRC removed the medications immediately for proper destruction.

iii. A RN identified that if a resident had a narcotic prescribed which needed to be crushed and the resident refused to take it, the registered staff placed the narcotic in the white bin under the sink in the medication room. The bin was made for regular (non monitored) medications that were awaiting destruction. The DRC stated that any narcotics, even if they were crushed, were required to be discarded as per the process in the home and placed in the wooden box in the DRC's office.

When monitored drugs were not properly destroyed, it increased the risk for misuse and risk for medication errors.

Sources: Observations of the medication storage and disposal area; review of the Drug Destruction and Disposal policy; interview with registered staff and the DRC
[561]

WRITTEN NOTIFICATION: QUARTERLY EVALUATION

NC#18 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 115 (1)

The licensee has failed to 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, met 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.

Rationale and Summary
The DRC stated that the home had no Professional Advisory Committee meetings in 2021, due to the pandemic and they had not evaluated the effectiveness of the medication management system in the home. The pharmacy consultant also stated that they had not been involved in the quarterly evaluations of the medication incidents in the home, even with the previous DRC.

Sources: Interviews with the DRC and Pharmacy Consultant [561]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF

NC#19 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 221 (1) 4.

The licensee has failed to ensure that PSWs received training on pain management.

Rationale and Summary
The DRC acknowledged that training was provided to the registered staff on pain management in 2021 but was not provided to PSWs. They reported that they were not aware that PSWs were required to receive training related to pain.

Sources: Training records; interview with the DRC and other staff [683]

WRITTEN NOTIFICATION: NON-ALLOWABLE RESIDENT CHARGES

NC#20 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 289 (1) ii under the FLTCA and under s. 245 (1) ii under the LTCHA, 2007.

The licensee has failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding that the licensee received from the Minister under section 90 of the Act.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 245 (1) ii of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 289 (1) ii of O. Reg. 246/22 under the FLTCA.

Rationale and Summary

A resident's substitute decision maker and other family members identified that they were being charged for basic foot care services. One of the family members indicated that an option to have the resident's toenails cut and trimmed by staff in the home was not provided on admission. PSW staff indicated that they had not provided basic foot care for residents in the home. Records of the resident and other residents in the home identified that a consent form was signed to pay a specified amount of money per visit every six to eight weeks for basic foot care. A list was obtained from the DRC with names of 34 residents that were being charged for basic foot care services. On admission, residents and/or power of attorney's were recommended to sign up for basic foot care which was being provided by an outside party and there was a fee for it. If the family was not willing to pay for the service, they were responsible to cut and trim their loved one's toenails.

The home's Foot Care policy indicated that basic and advanced foot care would be provided to residents by a RPN that had a certificate in basic and advanced foot care. This care would be provided on an additional pay for service basis.

Charging residents for basic foot care services was a non-allowable charge and increased the risk for residents to experience discomfort and infection if they were not able to pay and receive the service.

Sources: List of residents that were paying for basic foot care; consent forms; home's Foot Care policy; interviews with families, staff, and DRC [561]