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
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Original Public Report

Report Issue Date August 24, 2022
Inspection Number 2022_1493_0002
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
413 Linwell Road
St. Catharines, ON
L2M 2P3

Lead Inspector
Aileen Graba # 682

Inspector Digital Signature

Additional Inspector(s)
Lesley Edwards # 506
Emma Volpatti # 740883
Klarizze Rozal # 740765

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 4, 5, 9, 10, 11, 12, 15, 16 and 17, 2022

The following intake(s) were inspected:

- Log # 001641-22 for a complaint related to prevention of abuse and neglect
- Log # 002014-22, for Critical Incident System (CIS) report number 2994-0000001-22 related to prevention of abuse and neglect
- Log # 014101-22 for a complaint related to skin and wound and nutrition
- Log # 014417-22 for a complaint related to cooling requirements
- Log # 014455-22 for a complaint related to Infection Prevention and Control (IPAC), cooling requirements and skin and wound
- Log # 014527-22 for a complaint related to IPAC, bathing, cooling requirements, and care and services

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

- Continence Care
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

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

WRITTEN NOTIFICATION: PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (1) a.*

The licensee failed to ensure there was a written plan of care for a resident that set out the planned care for the resident related to bathing.

Rationale and Summary
A resident care plan identified that they preferred tub baths. Two Personal Support Workers (PSWs) both stated that the resident was provided a bed bath. The PSWs stated that they were verbally directed by registered staff to provide a bed bath due to an alteration in skin integrity. The bath schedule identified residents who received bed baths and the resident was not identified on the schedule to receive a bed bath. The PSW confirmed that the written plan of care did not set out the planned care for the resident related to bathing.

Failure to provide a written plan of care that set out the planned care put the resident at risk for not having their care needs met related to their current bathing interventions.

Sources: Complaint log, resident electronic medical record (EMR), the home's bath schedule, Family care conference, Interview with PSW other staff. [682]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s.6 (7).*

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The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan for continence care and management.

Rationale and Summary
Review of a resident's clinical record confirmed the resident was to be provided continence care at identified times. Observations and interview with two Personal Support Workers (PSWs) confirmed that they did not follow the resident's plan of care.

Failure to follow the resident's plan of care for continence care resulted in the resident not kept clean and dry with the potential for the resident to acquire skin breakdown.

Sources: Interview with PSWs and review of the resident's clinical record and observations. [506]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee failed to ensure that a resident who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Rationale and Summary
A resident had an alteration in skin integrity. A review of the clinical record indicated that for identified dates, the resident had weekly wound assessments not completed. The Nursing Administration Assistant confirmed that weekly wound assessments were not completed for the resident as required.

The risk of not completing weekly wound assessments for the resident was that staff could not evaluate if the wounds were worsening.

Sources: Resident skin and wound assessments; clinical record and interview with Nursing Administrative Assistant and other staff. [506]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee failed to ensure that a resident who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Rationale and Summary

A resident had an alteration in skin integrity that required assessments. The resident treatment records indicated that the resident's wounds were to be assessed weekly on an identified day. A registered nurse (RN) confirmed that the resident's alteration in skin integrity were scheduled to be assessed weekly and documented in the electronic medical record. A review of the clinical record for identified dates indicated the resident did not have weekly wound assessments of their altered skin integrity completed.

Because staff did not complete weekly skin assessments, the resident was put at risk for further alteration/deterioration in skin integrity as staff were unable to evaluate and/or take further action if required.

Sources: Resident electronic medical record (EMR); interview with RN and other staff. [682]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s. 24(1)(2).*

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. 24 (1) (2) of LTCHA.

The licensee failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

Rationale and Summary
A Critical Incident System (CIS) Report was submitted to the Director, reporting an allegation of abuse toward residents.

A) A resident's Substitute Decision Maker (SDM) reported alleged physical abuse to a resident to the Administrator/ Chief Executive Officer (CEO). When the CEO was made aware of the allegations, they did not immediately report the alleged abuse to the Director.

B) A Registered Practical Nurse (RPN) made a formal complaint to the CEO with allegations of physical and verbal abuse by another staff to two residents. The RPN confirmed that they also reported the allegations to the Director of Care (DOC) at the same time. The CEO did not immediately report the alleged abuse of the two residents by staff to the Director. The CEO confirmed that reporting to the Ministry was to be completed as soon as possible.

Sources: CIS Report, investigation documents, family meeting minutes, and emails, resident electronic medical records (EMR), interviews with RPN and CEO. [#740765]

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WRITTEN NOTIFICATION: AIR TEMPERATURES

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (3).

The licensee failed to ensure that the temperatures in the home were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every night.

Rationale and Summary

The home's temperature logs were reviewed. On identified days within the review period, the temperature documentation was missing either in the morning, between 12 p.m. to 5 p.m. and/or the evening. The Environmental Services Manager (ESM) confirmed that the temperatures were not measured and documented on those identified days.

By not measuring and documenting temperatures in the home at the required times, there was a risk of not identifying temperatures that may require corrective action.

Sources: Temperature logs; Interview with the ESM. [#740883]

WRITTEN NOTIFICATION: COOLING REQUIREMENTS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 23 (3)*

The licensee failed to ensure that their heat related illness prevention and management plan was evaluated and updated, at a minimum, annually in accordance with evidence- based practices.

Rationale and Summary

The home's policy titled "Hot Weather Season Procedures" was last revised on an identified date. The Director of Care (DOC) was unable to provide the inspector with an updated copy of the policy that included current evidence-based practices relating to cooling requirements. The DOC acknowledged that the policy was outdated.

By not updating the heat related illness prevention and management plan annually, it posed a risk to residents for not being provided up to date interventions on the prevention and management of heat related illnesses.

Sources: Interview with the Director of Care (DOC); home's policy titled "Hot Weather Season Procedures. [#740883]

WRITTEN NOTIFICATION: DOCUMENTATION

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NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (9).*

The licensee has failed to ensure the provision of care set out in the resident's plan of care was documented.

Rationale and Summary
On an identified date, there was missing documentation on care provided for identified residents. A Personal Support Worker (PSW) confirmed that the care was provided to the residents, but the documentation was not completed. The PSW Job Routine guide for the home's day shift indicated that at the end of each shift, POC should be checked to ensure that all documentation is complete. The DOC confirmed that staff should be documenting all care provided.

Sources: Interview with PSW, PSW Job Routine guide 0600-1400 shift, Interview with the DOC, The home's electronic medical record/Point of Care (POC). [#740883]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b).

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

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 10.4 (h), the licensee needed to ensure that there was support for residents to perform hand hygiene prior to receiving meals.

Observations of meal service identified two PSWs not hand sanitizing or encouraging residents to perform hand hygiene when they left a meal tray for two residents. Both PSWs stated that they should have assisted and cued both residents to perform hand hygiene at the time they delivered the tray. The Director of Care (DOC) was acting as the IPAC lead and indicated that the Public Health Ontario (PHO) 'Just Clean Your Hands' program is included in the home's IPAC resources and training. They confirmed that it was an expectation that staff encourage the residents to sanitize hands.

Failure to provide hand hygiene for resident prior to meals may have increased the risk of transmission of infections.

Sources: Observations; Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, Just Clean Your Hands-Long Term Care Public Health Ontario, Interview with DOC, PSWs [682]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b).

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

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 (e) the licensee used engineering controls, including: the use of barriers.

The home's infection prevention and control (IPAC) resources and training included COVID-19: Public Health Ontario; Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes. This resource identified that where infection risks to staff and residents cannot be eliminated, engineering controls and/or physical measures such as plexiglass were the preferred choice for controlling the risk of infection.

A screener was observed to be less than two metres of a visitor entering the home and not behind a plexiglass barrier or wearing eye protection. At the time the visitor was not wearing a face mask. The screener confirmed that they should be wearing eye protection when within two metres of visitors and not protected by a plexiglass barrier.

The home did not minimize the transmission risk of COVID-19 for its residents when staff did not follow the IPAC standard for Long Term Care and COVID-19 Public Health Ontario; Infection Prevention and Control checklist implemented to protect residents in long term care homes from COVID-19.

Sources: Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, COVID-19: Public Health Ontario; Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes; Observation of the screeners; interview with screener and other staff. [682]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 , s.184 (3).

The licensee failed to ensure that the home carried out the COVID-19 screening tool for Long-Term Care Homes and Retirement Homes as per section 9 of the Minister’s Directive: COVID-19 response measures for long term care homes (LTCHs).

LTCHs were required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long Term Care Homes was followed. LTCHs were required to follow this screening tool for minimum requirements and exemptions regarding active screening.

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The COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units document required homes to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home, as per the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes.

The COVID-19 Screening Tool for Long-Term Care Homes directed at a minimum, that all individuals entering the home were actively screened using specific questions. This included reviewing each symptom (ten in total) and asking a set of six questions related to their possible exposure to COVID-19.

Rationale and Summary

Observations identified that the home was in a facility wide COVID-19 outbreak. Observations identified visitors were allowed into the home by a screener. Visitors were asked if they had any general symptoms of COVID-19; however, were not asked the specific questions as outlined in the screening tool. The DOC stated they expected the screeners to review each required screening question with each visitor.

When individuals were not actively screened when entering the facility, all residents were placed at increased risk of transmission and possible exposure to COVID-19.

Sources: Observations of entrance screening; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 Screening Tool for Long Term Care Homes and Retirement Homes, COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, Outbreak management documentation/line lists, Interview with screener and DOC. [682]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s.102 (15) 1].

The licensee failed to ensure that the infection prevention and control lead designated worked regularly in that position on site at the home, with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

Rationale and Summary

Observations identified that the home was in a facility wide COVID-19 outbreak. The Director of Care confirmed that they assumed the role of IPAC lead. The DOC acknowledged that IPAC was not their primary focus and that the time spent on IPAC was less than 17.5 hours.

The residents were placed at risk for the transmission of infection when the staff designated as IPAC lead did not perform that function in compliance with specific IPAC provisions within the Regulations.

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Sources: Observations, Outbreak management documentation/line lists, Interview with the DOC, RN and other staff. [682]

WRITTEN NOTIFICATION: AVAILABILITY OF SUPPLIES

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 [s.48].

The licensee failed to ensure equipment that included a shower was readily available at the home to meet the personal care needs of residents.

Rationale and Summary

Two PSWs identified that the shower in the shower room had not been used due to accessibility issues and risk for resident injury with transfers. A PSW identified that the base of the shower was elevated and that they could not securely transfer a resident over the transition into the shower. The PSW also stated that the shower had not been used for an identified period of time. The Environmental Services Manager (ESM) stated that they were aware that residents were not being showered in the shower room. Observations identified that the only shower room in the home was currently used for storage of extra equipment and not resident care.

Because shower equipment was not readily available, residents personal care needs including appropriate measures for hygiene/showering was placed at risk.

Sources: Observations, Resident electronic medical record (EMR), Interview with PSW, ESM and other staff. [682]

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;

(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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