Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: December 7, 2023

Inspection Number: 2023-1493-0005

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Niagara Ina Grafton Gage Village

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

Lead Inspector	**Inspector Digital Signature**
Emily Robins (741074)	Emily C Robins Digitally signed by Emily C Robins Date: 2023.12.29 11:39:35 -05'00'

Additional Inspector(s)
Olive Nenzeko (C205)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 20, 21, 23, 24, 28-30, 2023.

The following intakes were inspected:
· Intake #00098454 – Complainant with concerns for resident regarding plan of care and duty to protect.
· Intake #00098512 [Critical Incident Report (CIR) #2994-000010-23] - Improper/Incompetent treatment of resident by staff.
· Intake #00098877 - Complainant with concerns for resident regarding administration of drugs, pain management, transferring and positioning, plan of care, personal care, baths, foot care, nail care and laundry service.

· Intake #00099251 [CIR #2994-000012-23] - Improper/Incompetent treatment of resident by staff.
· Intake #00099301 - Follow-up #: 1 - CO #002 from Inspection #2023-1493-0004 regarding O. Reg. 246/22 - s. 140 (2) CDD November 10, 2023.
· Intake #00099302 - Follow-up #: 1 – CO #001 from Inspection 2023-1492-0004 regarding FLTCA, 2021 - s. 184 (3) CDD November 10, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1493-0004 related to FLTCA, 2021, s. 184 (3) inspected by Emily Robins (741074)

Order #002 from Inspection #2023-1493-0004 related to O. Reg. 246/22, s. 140 (2) inspected by Olive Nenzeko (C205)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to ensure a resident's lifestyle and choices were respected.

Rationale and Summary

A resident requested on multiple occasions that two Personal Support Workers (PSW) assist them with a few comfort measures. These two PSWs, on several occasions, did not comply with the resident's requests for comfort measures to be provided.

Failing to provide the requested comfort measures may have impacted the resident's comfort and well-being.

Sources: Critical Incident Report #2994-000010-23, written complaint, the home's response, the home's investigation notes, warning letter, and interview with staff [C205].

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident.

A) Rationale and Summary

A resident's written plan of care indicated that they were to receive baths on specified days and as needed. The resident indicated that sometimes when staff approach them for their bath, they do not feel the time is suitable for them and an alternate bath time is not provided. They indicated that their preference is to have an alternate time provided in this case.

Two Personal Support Workers (PSWs) outlined in separate interviews what they had found to be effective if the resident refused their bath at the specified time.

Staff, including the Director of Care (DOC), indicated that this direction was not captured in the resident's written plan of care, but that it should be to provide clear direction to all staff and others who provide direct care to the resident.

Sources: Resident's care plan, kardex, tasks, look back report, bathing documentation sheets and interviews with resident and staff.

B) Rationale and Summary

The Treatment Administration Record (TAR) for a resident indicated that nursing staff were to complete a monthly dry skin audit for this resident one time a day starting on the 13th and ending on the 13th every month.

Only three audits were documented for this resident. The Charge Nurse indicated that the written plan of care for this resident was not clear, in that it does not specify which nursing shift was to complete this audit tool on the specified day, likely resulting in the tool not being completed monthly.

Sources: Resident's Treatment Administration Record, monthly dry skin audits, and interviews with staff [741074].

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

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

Rationale and Summary

A resident's plan of care identified that they required two staff to assist them with a

specified aspect of their personal care.

On a specified date, only one staff member was present, and the resident had a fall. The Director of Care (DOC) acknowledged that there should have been two staff providing care to the resident at the time of the incident.

Failure to follow the resident's plan of care by ensuring two staff were present increased the risk of a fall with injury.

Sources: Resident's clinical records, investigation notes, complaint from resident's family member and interview with DOC [C205].

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
Staff and others to be kept aware
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Rationale and Summary

A resident's plan of care indicated that a Personal Support Worker (PSW) was to apply stock lotion to their skin once a day.

A PSW who looks after the resident at times indicated that they were unaware that the resident was to have any lotion applied at the specified time. A nurse indicated that the PSWs do not have access to the part of the plan of care where this direction is captured.

Failure to ensure that the staff who provide direct care to this resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it likely contributed to the resident not receiving this care.

Sources: Resident's TAR November 2023, Kardex, and interviews with staff [741074].

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary

A resident's plan of care indicated that staff were to empty and clean their urinal

each shift and document this in the point of care (POC) system. A review of this POC documentation and interview with the Director of Care (DOC) confirmed that the provision of this care was not documented each shift.

Sources: Resident's look back report and interviews with staff [741074].

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure that they immediately forwarded to the Director a written complaint that was received concerning the care of a resident.

Rationale and Summary

On a specified date the Director of Care (DOC) received an email from a resident 's family member identifying concerns related to the resident's care.

The home's complaint binder included this complaint as well as investigation notes and actions taken by the home however, the complaint was not forwarded to the Director.

Sources: Emailed complaint from resident's family member, 2023 complaint binder, investigation notes and interview with staff [C205].

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, received immediate treatment and interventions to promote healing, as required.

Rationale and Summary

A resident had altered skin integrity. On a specified date, a Registered Practical Nurse (RPN) noted signs of infection and worsening of one of the areas of altered skin integrity and the resident was started on an antibiotic. The same RPN reassessed the wound a week later. At this time, they indicated that the wound was still infected and that the resident was on an antibiotic however, their antibiotic course was actually completed at this time.

The RPN admitted that they had mistakenly assumed the resident was on antibiotics at the time of this assessment and, had they known the resident was no longer on

an antibiotic for the infection, they would have swabbed the wound and notified the physician at that time. A week later the wound was swabbed and the resident was started on a new antibiotic a few days after that.

Failure to ensure that this resident who was exhibiting altered skin integrity received immediate treatment and interventions to promote healing as required likely contributed to the transient worsening of their wound.

Sources: Resident's orders, progress notes, antibiotic tracking tool, and interviews with staff [741074].

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response.

The licensee has failed to ensure that a documented record for a complaint was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary

On a specified date, a resident's Substitute Decision Maker (SDM) emailed the Director of Care (DOC) a written complaint about the care of the resident. The complaint was investigated, and actions were taken to address the complainant's concern. No documentation was found regarding any responses provided to the complainant.

The Director of Care (DOC) stated that they responded verbally to the SDM about their concern and that no response to their written complaint was documented in the complaint binder.

Failure to keep a record of the responses provided to the complainant about their concerns raised the risk of issues being left unresolved.

Sources: 2023 complaint binder, workplace complaint form, investigation notes, progress notes and interview with staff [C205].