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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: April 3, 2025
Inspection Number: 2025-1493-0002
Inspection Type: Critical Incident
Licensee: Niagara Ina Grafton Gage Village
Long Term Care Home and City: Niagara Ina Grafton Gage Village, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): March 28, 31, 2025 and April 1, 2, 3, 2025

The following intake (s) were inspected:

- Intake: #00133020 -[Critical Incident (CI) 2994-000028-24] related to Responsive Behaviours and Safe and Secure Home.
- Intake: #00140893 - [CI: 2994-000002-25] related to Infection Prevention and Control.

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for a resident, as they were able to elope through the front entrance of the home without their medical device triggering an alert.

Sources: Critical Incident Report, the home's Wander Resident Alert Process policy, and staff interview.

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)
Plan of care
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 has failed to ensure that a resident was monitored as specified in their written plan of care. Their clinical records showed that they were not monitored as required on several shifts over a specific period of time.

Sources: A resident's clinical records, the home's Wandering Resident Alert Process policy, and staff interview.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (b)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the home's responsive behaviours program was evaluated and updated annually in accordance with evidence-based practices and if there were none, in accordance with prevailing practices.

Staff indicated that the program had never been evaluated, and that they were in the process of initiating an evaluation.

Sources: The home's Wander Resident Alert Process policy, and staff interview.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (e)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,
(e) that the program is evaluated and updated at least annually in accordance with the standards and protocols issued by the Director under subsection (2);

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

the Director under subsection (2).

Record review of the home's IPAC program did not generate any information to support that an evaluation was completed. Staff confirmed that the program had never been evaluated, and that they were in the process of initiating an evaluation.

Sources: Record Reviews of the IPAC program and staff interview.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak that was declared by a Public Health Unit on a specified date in February 2025. The home acknowledged that they did not report the incident until a day later.

Sources: Critical Incident System (CIS) report; email correspondence with a Public Health Unit; Outbreak Management Checklist and staff interview.

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