Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 2, 2016	2016_248214_0009	012149-16	Resident Quality Inspection

Licensee/Titulaire de permis

NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH
413 Linwell Road St. Catharines ON L2M 7Y2

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

INA GRAFTON-GAGE HOME
413 Linwell Road St Catharines ON L2M 7Y2

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

CATHY FEDIASH (214), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 3, 4, 5, 9, 10, 11, 12, 13, 16, 17, 18, 2016.

Please Note: The following inspections were conducted simultaneously with this Resident Quality Inspection:
-Critical Incident Inspection #000346-16 related to transfers.
-Complaint Inspection #013910-16 related to speaking with Inspector's.
-Follow up Inspection #035136-15 related to Registered Nurse staffing.
-Follow up Inspection #035137-15 related to care provided as specified in the plan.
-Follow up Inspection #035138-15 related to duty to protect.
-Follow up Inspection #035139-15 related to Residents' Bill of Rights.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, Personal Support Workers (PSW), activation/recreation staff, residents and families. During the course of this inspection, the inspector's toured the home; reviewed resident health records; reviewed meeting minutes; reviewed relevant policies and procedures; reviewed a Critical Incident Submission; reviewed investigation records, reviewed staff training records and observed resident's in dining and care areas.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

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

11 WN(s)
3 VPC(s)
1 CO(s)
1 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2015_323130_0026	583
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #004	2015_323130_0026	583
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2015_323130_0026	214

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one Registered Nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A review of the Registered Staffing Schedule for an identified period of time in 2016, indicated that a Registered Nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home on at least 66 shifts out of 90.

An interview with the DOC on an identified date in 2016, confirmed that the home did not have an RN for these regular scheduled shifts and where possible, the shifts were replaced by a Registered Practical Nurse (RPN). The DOC confirmed the home has been unsuccessful in recruiting Registered Nurses despite their efforts. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

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

A) A review of the toileting plan of care for resident #101 identified they required physical assistance from one staff member and were to be taken to the toilet after each meal. The paper kardex posted at the resident’s bedside directed staff to take resident #101 to the toilet before each meal. If resident #101 was not able to void or defecate before the meal staff were to toilet again after the meal. In an interview with the DOC on an identified date in 2016, it was confirmed the toileting plans did not provide clear direction to staff. It was confirmed that the direction posted on the kardex in the resident’s room was the current toileting plan. (Inspector #583)

B) A review of a Critical Incident Submission (CIS) submitted by the home indicated that on an identified date in 2016, resident #103 sustained an injury to an identified area on their body following a fall using specified equipment.

A review of the paper kardex posted at the resident’s bedside indicated that just prior to the incident the resident was to be transferred using specified equipment for the purpose of toileting. A review of the written care plan in place just prior to this incident indicated under the transfer and toilet focus that staff were to transfer the resident on and off the toilet; however, the care plan had not specified how this was to be done.

An interview with the DOC confirmed that the written plan of care had not set out clear directions to staff and others on how the resident was to be transferred for the purpose of toileting.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000346-16, conducted concurrently during this Resident Quality Inspection. (Inspector #214) [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) A review of a CIS submitted by the home indicated that on an identified date in 2016, resident #103 sustained an injury to an identified area on their body following a fall using specified equipment.

A review of the Resident Assessment Protocol (RAP) for Activities of Daily Living (ADL) - Functional Rehabilitation Potential completed most prior to this incident and dated on an identified date in 2015, indicated that the resident was assessed to require toileting by two staff using specified equipment. A review of the written care plan in place at the time of this assessment indicated under the focus for transfer and toileting that no interventions were in place that identified that the resident required the use of specified equipment for toileting purposes.

An interview with the DOC confirmed that the care set out in the plan of care had not been based on the assessed transfer and toileting needs and preferences of the resident.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000346-16, conducted concurrently during this Resident Quality Inspection.

B) A review of resident #107's Minimal Data Set (MDS) coding dated on an identified date in 2016, indicated under section G. Physical Functioning and Structural Problems that the resident was coded under toilet use as requiring extensive assistance of two or more staff. A review of the corresponding narrative Functional Rehabilitation Potential RAP completed on the same date, indicated that the resident required staff assistance for the purpose of toileting. A review of the resident's written care plan indicated under the toileting focus that the resident required total assistance of two staff for the entire toileting process. An interview with PSW staff #107 and #133, confirmed that the resident required extensive assistance of two staff for their toileting needs.

An interview with the DOC confirmed that the care set out in the plan of care had not been based on the assessed toileting needs and preferences of the resident.

C) A review of resident #109's MDS coding dated on an identified date in 2016, indicated under section G. Physical Functioning and Structural Problems that the resident was coded under toilet use as requiring extensive assistance of two or more staff. A review of the corresponding narrative Functional Rehabilitation Potential RAP completed on the same date indicated that the resident was toileted with two staff and the use of specified equipment. A review of the resident's written care plan indicated under the toileting focus that the resident required total assistance of two staff for the entire toileting process.

An interview with the DOC confirmed that the resident required extensive assistance for their toileting needs and that the care set out in the plan of care had not been based on the assessed toileting needs and preferences of the resident. [s. 6. (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 the written plan of care for each resident set's out clear directions to staff and others who provide direct care to the resident and to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

During stage one of the Resident Quality Inspection staff interviews as well as a review of the clinical record for resident #102 indicated that the resident demonstrated an alteration to their skin integrity to an identified area that had been present for approximately three days.

During a review of the resident's clinical record approximately 10 days following the resident acquiring the altered skin integrity, it was indicated that a referral to the dietitian to assess the resident's altered skin integrity could not be located. An interview with the DOC confirmed that the home completed a paper referral to the dietitian when an alteration in skin integrity occurred and that a referral for resident #102 had not been completed. [s. 50. (2) (b) (iii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

A) During observation of the lunch hour medication administration pass on an identified date in 2016, registered staff #126 was observed to have administered a prescribed medication to a resident in their room. Upon return to the medication cart it was observed that the medication cart had been left unlocked. It was observed that the medication cart was located in the main hallway of the unit and around the corner from the resident's room where the prescribed medication had just been administered. Residents of the home were in the immediate vicinity of the medication cart. The registered staff member confirmed that the medication cart was to be locked when not in attendance.

B) On an identified date in 2016, at approximately 0910 hours, a medication cart was observed to be to be in the hallway with no staff present or in view of the medication cart. The medication cart was observed to be unlocked with two liquid medications that were orange in colour and dispensed into plastic medication cups, sitting on the top of the cart. It was also observed that two bottles of a liquid prescribed medication were also sitting on the top of the medication cart. The Long Term Care Homes (LTC) Inspector remained at the medication cart for approximately 4 minutes when a door to a resident's room directly across from the medication cart opened and registered staff came out. An interview with the DOC confirmed that drugs were to be stored in the medication cart and that the medication cart was to be secured and locked when not in attendance.

C) An interview with the DOC confirmed that routine prescribed controlled substances were dispensed into medication packages with routine prescribed non-controlled substances. The DOC confirmed that the routine controlled substances had not been stored in a separate locked area within the locked medication cart. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart that is secured and locked and to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) In an interview with the DOC on an identified date in 2016, it was confirmed that resident #101 was to be toileted before each meal and if they were not able to void or defecate staff were to toilet the resident again after the meal. A review of the Point of Care (POC) documentation for toileting was reviewed for an identified period of seven days in 2016. There was no documentation of resident #101 being toileted before meals or after breakfast. On one identified date during the review period, it was documented that resident #101 was toileted after lunch and three times on three other identified dates during the review period it was documented that resident #101 was toileted after dinner. In an interview with the DOC it was confirmed that not all actions in relation to resident #101's toileting plan were documented. (Inspector #583)

B) A review of resident #107’s current written care plan indicated under the urinary and bowel incontinence focus that interventions in place were that staff were to toilet the resident in the morning, after meals, every bedtime and to check and change the resident's incontinent product through the night time hours. A review of the POC documentation system for toileting on three identified dates in 2016, indicated that the resident was documented as being toileted once at 0321 hours on the first date reviewed; once at 0503 hours on the second date reviewed and once at 0345 hours on the third date reviewed.

An interview with PSW staff #107 and #133, confirmed that the resident was toileted minimally four to five times through the day and evening shifts and was checked and changed during the night shift.

An interview with the DOC confirmed that when the resident was toileted, not all of these actions had been documented. (Inspector #214)

C) A review of resident #109’s current written care plan indicated under the urinary and bowel incontinence focus that interventions directed staff to toilet the resident in the morning, after meals, every bedtime and that the resident was checked and changed through the night time hours. A review of the POC documentation system for toileting on three identified dates in 2016, indicated that on the first date reviewed the resident was documented as being toileted once at 0519 hours; on the second date reviewed, documentation indicated the resident was toileted at 0501hours and 2347 hours and on the third date reviewed, documentation indicated the resident was toileted at 0751 hours.

An interview with the DOC confirmed that the resident was toileted several times through the day and evening and was checked and changed during the night time hours during this review period. The DOC confirmed that when the resident was toileted, not all of these actions had been documented. (Inspector #214) [s. 30. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents being restrained by a physical device were released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations.

A review of the plan of care for resident #102 and #108 identified they used a physical device when up in their wheel chair. A review of the POC documentation for each resident identified staff were to complete checks every hour and reposition the residents every two hours when the physical device was in use. In an interview with staff #111, #163, #169 and #176, it was identified that resident #102 and #108 were repositioned between 0830 hours and 1230 hours on an identified date in 2016, using the tilt applications on their wheel chairs. The staff confirmed that the residents were not released from their physical device and repositioned in accordance with the requirements. In an interview with the DOC it was confirmed that directions in the POC documentation system had not directed staff to release the physical device when repositioning every two hours. [s. 31. (3) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident in the home was bathed, at a minimum, twice a week by the method of his or her choice.

A review of the plan of care for resident #104 identified their preference was to have a tub bath on two identified days of the week. In an interview with resident #104 on an identified date in 2016, they shared they did not receive their scheduled bath on one of their scheduled bathing days due to a staffing shortage. A review of the POC documentation records identified the resident did not receive a bath on this date, and only received one bath that week. In an interview with the DOC it was confirmed that resident #104 was not offered and had not received two baths for the week reviewed. [s. 33. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;   O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) A review of resident #104’s MDS coding dated on an identified date in 2015, indicated under section H. Continence in last 14 days that the resident was coded as being incontinent of their bowels. A review of the MDS coding dated on an identified date in 2016, indicated under section H. Continence in last 14 days that the resident was coded as being usually continent of their bowels.

B) A review of resident #107’s Minimum Data Set (MDS) coding dated on an identified date in 2015, indicated under section H. Continence in last 14 days that the resident was coded as being frequently incontinent of their bowels. A review of the MDS coding dated on an identified date in 2016, indicated under section H. Continence in last 14 days that the resident was coded as being occasionally incontinent of their bowels.

C) A review of resident #109’s Minimum Data Set (MDS) coding dated on an identified date in 2015, indicated under section H. Continence in last 14 days that the resident was coded as being frequently incontinent of their bowels. A review of the MDS coding dated on an identified date in 2016, indicated under section H. Continence in last 14 days that the resident was coded as being usually continent of their bowels.

An interview with the DOC confirmed that the home conducted an assessment of a resident’s incontinence using the MDS RAP which was designed for the assessment of urinary incontinence only. The DOC confirmed the home did not have a clinically appropriate assessment instrument in place that was specifically designed for assessment of a resident’s urinary and/or bowel incontinence. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours where possible.

A review of the MDS RAI quarterly assessment for resident #104 completed on an identified date in 2016, indicated they demonstrated identified responsive behaviours. In an interview with the DOC and staff #160 and through a review of the progress notes it was confirmed that resident #104 continued to demonstrate these responsive behaviours. A review of resident #104's care plan identified that strategies had not been developed and implemented to respond to these behaviours. This was confirmed in an interview with the DOC on an identified date in 2016. [s. 53. (4) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee failed to ensure that where a Residents’ Council was established in the home; only residents of the long-term care home were members of the Residents' Council.

During an interview on an identified date in 2016, with resident #300 who attended the Residents’ Council meetings as well as a family member who attended the meetings, it was shared that the home conducted joint Residents’ and Family Council meetings where both residents and family members attended together.

An interview with the DOC confirmed that there is no president for either the Residents’ Council or the Family Council and that the home conducts a joint meeting where both resident’s and family members attend together. [s. 56. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that they sought the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

An interview on an identified date in 2016, with resident #300 who attended the Residents’ Council meeting indicated that the Satisfaction Survey was distributed in the last year and that the Residents’ Council were not sought out for their advice in developing and carrying out the Satisfaction Survey. An interview with the DOC confirmed that the advice of the Residents’ Council was not obtained in developing and carrying out the Satisfaction Survey and in acting on its results. [s. 85. (3)]

Issued on this 17th day of June, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2016_248214_0009
Log No. / Registre no:	012149-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 2, 2016
Licensee / Titulaire de permis :	NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH 413 Linwell Road, St. Catharines, ON, L2M-7Y2
LTC Home / Foyer de SLD :	INA GRAFTON-GAGE HOME 413 Linwell Road, St Catharines, ON, L2M-7Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PATRICK O'NEILL

To NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_323130_0026, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee failed to ensure that at least one Registered Nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A review of the Registered Staffing Schedule for an identified period of time in 2016, indicated that a Registered Nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home on at least 66 shifts out of 90.

An interview with the DOC on an identified date in 2016, confirmed that the home did not have an RN for these regular scheduled shifts and where possible, the shifts were replaced by a Registered Practical Nurse (RPN). The DOC confirmed the home has been unsuccessful in recruiting Registered Nurses despite their efforts.

The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.8 (3) of the Act, in respect of the potential for harm to all resident's, the scope of "widespread" within the context of a Resident Quality Inspection, and the Licensee's history of ongoing non-compliance (CO) on July 20, 2014 and November 23, 2015, Resident Quality Inspection's related to s.8(3). (214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

Service Area Office /
Bureau régional de services : Hamilton Service Area Office