



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**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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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 9, 2017	2016_323130_0023	018256-16, 020063-16	Critical Incident System

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**Licensee/Titulaire de permis**

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

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

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

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

GILLIAN TRACEY (130)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 1 and 2, 2016.**

**During this inspection, resident care was observed, staff were interviewed, clinical records were reviewed, as well as quality indicators, Residents' Council minutes and relevant policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Resident Care, registered staff, personal support workers (PSWs), residents and families.**

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

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

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



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**WN #1: 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) Resident #001 had an alteration in skin to an identified area, which required a specific treatment at specified times, as per their plan of care. According to their plan of care the treatment was signed for as completed, by registered staff #303, on an identified date in 2016; however, registered staff #303 did not document their assessment of the alteration in skin.

The DRC confirmed the staff completed the treatment on the identified dates, but failed to document their assessment of the resident in their clinical record. (Inspector #130). [s. 30. (2)]

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**Issued on this 10th day of January, 2017**

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



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**Original report signed by the inspector.**