Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 23, 2019	2019_560632_0015	012272-19	Complaint

Licensee/Titulaire de permis

Niagara Ina Grafton Gage Village
413 Linwell Road St. Catharines ON L2M 7Y2

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

Niagara Ina Grafton Gage Village
413 Linwell Road St. Catharines ON L2M 7Y2

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

YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 21, 24, 25, 2019.

The following Complaint inspection was completed:
Log #012272-19 - related to nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Director Residents Care (DRC), Dietary Aide (DA), personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), residents and their families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documentation, including clinical health records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee shall ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of the written plan of care for resident #002 directed staff to provide support at meals and snacks.

On an identified date in June 2019, a distribution of snacks was observed in the home. Resident #002's nourishment was provided to the resident, while the resident was in an identified location. PSW #107 was interviewed on an identified date in June 2019, and could not recall if support was provided to resident #002 on an identified date in June 2019.

On an identified date in June 2019, PSW #102 indicated that it was PSWs' usual routine to provide support to residents. PSW #102 and PSW #107 indicated that on an identified date in June 2019, they did not recall if support was provided to resident #002. PSW #105 indicated that an identified support for residents was not provided, since they were involved in other duties.

The home failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in their plan. [s. 6. (7)]

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 and ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of specified patterns and interventions.

A. Complaint log #012272-19 (IL-56936-TO) submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in May 2018, identified concerns related to assistance provided with feeding for resident #001.

Review of the written plan of care directed staff to provide support at meals and snacks.

On an identified date in June 2019, a distribution of snacks was observed in the home. Resident #001 was involved in an identified activity when the nourishment and assistance were provided to the resident, as needed, until an identified period of time.

Interview with PSW #102, on an identified date in June 2019, indicated that support was provided to resident #001 after a specific activity. Interview with the DRC, on an identified date in June 2019, confirmed that the plan of care did not identify interventions describing specified patterns and preferences based on interdisciplinary assessment of resident #001, related to the support the resident required was to be provided after a specific activity.

The home failed to ensure that plan of care for resident #001 was based on, at a minimum, interdisciplinary assessment of specified patterns and interventions.

B. Review of the written plan of care for resident #002 directed staff to provide an identified support at meals and snacks. The written plan of care also indicated that the resident had identified ability.

On an identified date in June 2019, a distribution of snacks was observed in the home. During the observation period, resident #002's was in an identified state, in an identified location and an identified activity with nourishment was performed. An identified support was not offered to resident #002.

Interview with PSW #102 on an identified date in June 2019, indicated that it was PSWs' usual routine to provide an identified support to residents. On an identified date in June 2019, PSW #102 and #107 indicated that on an identified date in June 2019, they did not recall if an identified support was provided to resident #002. Interview with the DRC on

an identified date in June 2019, confirmed that the plan of care did not identify interventions describing specified patterns and preferences based on interdisciplinary assessment of resident #002.

The home failed to ensure that plan of care for resident #002 was based on, at a minimum, interdisciplinary assessment of specified patterns and interventions.

C. Review of the written plan of care for resident #003 directed staff to perform an identified activities at meals and snack for the resident.

On an identified date in June 2019, a distribution of snacks was observed in the home. During the observation period, resident #003 had identified activity and an identified activity was performed with the nourishment for resident #003. An identified support was not offered to the resident.

Interview with PSW #102 on an identified date in June 2019, indicated that it was PSWs' usual routine to provide an identified support to residents. On an identified date in June 2019, PSW #107 indicated that they provided an identified support to resident #003. Interview with the DRC on an identified date in June 2019, confirmed that the plan of care did not identify interventions describing specified patterns and preferences based on interdisciplinary assessment of resident #003.

The home failed to ensure that plan of care for resident #003 was based on, at a minimum, interdisciplinary assessment of specified patterns and interventions. [s. 26. (3) 21.]

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 and ensuring that plan of care is based on, at a minimum, interdisciplinary assessment of sleep patterns and interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

A. Complaint log #012272-19 (IL-56936-TO) submitted to the MOHLTC on an identified date in May 2018, identified concerns regarding assistance provided to resident #001 with nourishment.

On an identified date in June 2019, an identified activity was observed. The nourishment was delivered to resident #001's identified location at identified period of time and was kept at identified temperature for identified period of time.

Review of the plan of care directed staff to perform an identified activity for resident #001.

On an identified date in June 2019, PSW #102 indicated that on an identified date in June 2019, an identified assistance with eating was provided to resident #001 and it was a usual routine for staff. RN #106 confirmed that identified assistance with nourishment to resident #001 was to be provided by the PSW, scheduled to come at a specific time.

Review of Food Service Temperature Policies and Procedures Number: FS-08-09-01, indicated that identified foods were to be held in identified equipment or in a specified location to maintain an identified temperature.

On an identified date in June 2019, the DRC indicated that an identified food product was to be kept in specified equipment right before the consumption and resident #001 was not provided with food that was specifically stored.

The licensee failed to ensure that resident #001 was provided with food that was specifically stored.

B. On an identified date in June 2019, an identified activity was observed. The nourishment was delivered to resident #002's identified location and was kept at identified temperature in identified location until identified period of time.

Review of the written plan of care directed staff to perform an identified activity at meals and snacks. The written plan of care also indicated that the resident was involved in an identified activity and had identified interventions in place.

On an identified date in June 2019, PSW #102 indicated that assistance with eating was provided to resident #002 and it was a usual routine for staff. RN #106 confirmed that an identified assistance with feeding to resident #002 was to be provided by PSW, scheduled to come at an identified period of time.

Review of Food Service Temperature Policies and Procedures Number: FS-08-09-01 indicated that identified foods were to be held in an identified equipment or in specified location to maintain an identified temperature.

On June 2019, the DRC indicated that an identified food product was to be kept in an identified equipment right before the consumption.

The licensee failed to ensure that resident #002 was provided with food that was specifically stored. [s. 11. (2)]

Issued on this 20th day of August, 2019

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

Original report signed by the inspector.