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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Original Public Report

Report Issue Date: April 28, 2023

Inspection Number: 2023-1493-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Niagara Ina Grafton Gage Village

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

Lead Inspector	**Inspector Digital Signature**
Emily Robins (741074)	Emily C Robins Digitally signed by Emily C Robins Date: 2023.05.29 12:47:23 -04'00'

Additional Inspector(s)
Karlee Zwierschke (740732)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11-14, 17-18, 2023.

The following intake(s) were inspected:

· Intake #00017887 - Anonymous complaint with concerns regarding dining and snack service; food service workers, training and qualification.

· Intake #00018444 - Fall of resident resulting in fracture.

· Intake #00019252 - Fall of resident resulting in fracture.

· Intake #00019414 - Complaint on behalf of resident with concerns related to plan of care, personal care, and residents' bill of rights. Related to intake #00019252.

The following intakes were completed in this inspection:

· Intake #00007630, Intake #00009075 and Intake #00016297 were all related to falls that resulted in a fracture.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 3 (1) 19. iv.

The licensee failed to ensure that every residents' personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

Rational and Summary

Inspector #741074 noted on two separate days that a list of residents' weights with their names beside them was taped to the counter of the nursing station (public facing). The Director of Care (DOC) was notified of this on the second day at which point the DOC indicated that residents' weights would be considered personal health information and that they should not be kept there to ensure this information is kept confidential.

Inspector noted on the same day that the DOC was notified about the list that it had been removed from the counter of the nursing station and was no longer visible to the public.

Sources: Observations of nursing station and interview with the DOC. [741074]

Date Remedy Implemented: April 17, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

Rationale and Summary

The plan of care for a resident specified an intervention to manage falls. A Personal Support Worker (PSW) and two Registered Practical Nurses (RPN) indicated that this intervention was no longer in place for this resident.

The plan of care was updated to reflect this change.

Sources: Resident's clinical record, interview with DOC, PSW and RPNs. [740732]

Date Remedy Implemented: April 14, 2023

WRITTEN NOTIFICATION: Resident's Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to ensure that a resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

Rationale and Summary

A resident's family member had not been their Substitute Decision Maker (SDM) for several years. This was confirmed by the Director of Care.

Six times in one month earlier this year this resident's family member was incorrectly referred to in the progress notes as their Power of Attorney by registered staff. A Registered Nurse (RN) indicated that in the same month they had left a message for the family member in relation to medication changes made. It was also documented in a progress note that the family member was given a copy of the resident's Medication Administration Record with no documentation of consent from the resident to do so.

The DOC indicated that the family member was to be given general information about the resident's health only but that at times the staff felt pressured to provide more. The Administrator indicated that

the home had provided the family member with written confirmation that since they were not the resident's SDM, they were unable to provide specific details of the resident's health conditions or treatment and that this information should be obtained from the resident themselves.

Failure to protect the resident's personal health information violated the resident's right to choose what information is shared.

Sources: Resident's chart, interview with Director of Care and Administrator, letter from the home to the resident's family member. [741074]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

The plan of care for a resident included a specific falls prevention intervention. The resident had a fall and progress notes indicated that the intervention was not in place at the time of the fall. A RPN confirmed this.

Not having this falls prevention strategy in place as per the plan of care would have made it more difficult to prevent the fall.

Sources: Resident's clinical record and interview with RPN. [740732]

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care for a resident, specifically bathing, dressing, hygiene and oral care as set out in the plan of care was documented.

Rationale and Summary

A resident's Documentation Survey Report for one month demonstrated that care related to bathing was not documented on one of their assigned bath days; care related to dressing was not documented on eleven different days during day shift and nine different days during night shift; care related to hygiene was not documented on eleven different days on day shift and on eleven different days on night shift; and oral care was not documented on eleven different days on day shift and on eleven different days on night shift.

The DOC indicated that documentation of care provided was required to ensure the resident received the care they need. They confirmed that where the Documentation Survey Report shows blank spaces, care for this resident was not documented.

Failure to document personal care provided to the resident put them at risk of not receiving the level of assistance and care required.

Sources: Resident' Documentation Survey Report, Task List Report and Care Plan and interview with the DOC. [741074]

WRITTEN NOTIFICATION: Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The Licensee has failed to ensure that the Physician's assessment of a resident under the Medical Services program was documented.

Rationale and Summary

On a specified date, a Physician who was covering for the Physician for the home discontinued ten of a resident's medications.

Review of the resident's electronic and physical chart and the Physician communication binder demonstrated that there was no record of the Physician's assessment of this resident on or around the time the medications were discontinued. The Director of Care indicated that the Physician's assessments should be documented in a progress note in the physical chart and that a covering Physician would be held to this same standard. A RN confirmed that the covering Physician did not document their assessment of this resident.

Failure to document the Physician's assessment of the resident put the resident at risk of improper care by reducing the level of accountability and diminished the quality of communication amongst the health care team.

Sources: Resident's electronic Medication Administration Record, electronic progress notes and physical chart, the home's Physician communication binder, interview with RN and the Director of Care. [741074]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident had an unwitnessed fall and was taken to hospital approximately one hour later. Documentation outlining the details of the fall and the actions taken following demonstrated that it was unknown whether the resident hit their head or not, and that their initial vitals were not taken.

The Director of Care reviewed the resident's electronic medical record and indicated that an initial set of vitals would be part of the required post fall assessment when a fall was unwitnessed. This part of the post fall assessment was not completed in relation to the specified fall.

Failure to assess resident's vitals post fall placed them at risk of undiagnosed injury from the fall and subsequent falls.

Sources: Resident's progress notes and interview with the Director of Care. [741074]