Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
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Original Public Report

Report Issue Date: May 8, 2024	
Inspection Number: 2024-1493-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Niagara Ina Grafton Gage Village	
Long Term Care Home and City: Niagara Ina Grafton Gage Village, St Catherines	
Lead Inspector Betty Jean Hendricken (740884)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2-4, 9-12, 23 and 24, 2024.

The following intake(s) were inspected:

- Intake: #00108822 - critical incident related to infection prevention and control.
- Intake: #00109919 -complaint related to resident care and services.

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report the suspicion of abuse that resulted in risk of harm to resident #001 and the information upon which the abuse was based, to the Director.

Rationale and Summary
On a day in March 2024, abuse of a resident was reported to the Director of Care (DOC) and the DOC failed to immediately report to the Director.

The DOC confirmed that they were made aware of the allegation of abuse and failed to immediately report to the Director. A Critical Incident was submitted to the Director on a day in April 2024.

Sources: DOC Interview, Critical Incident review.
[740884]

WRITTEN NOTIFICATION: Housekeeping - Cleaning and Disinfecting Resident Equipment

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee failed to implement procedures for cleaning and disinfecting resident care equipment.

Rationale and Summary
On a day in April 2024, it was observed that the lift used to transfer residents was not cleaned and disinfected after being used to transfer a resident. Two staff exited a resident room with the lift and, without cleaning and disinfecting it, placed it in the hallway and went on to complete other tasks. One staff confirmed that the lift was not cleaned and disinfected after it was used to transfer a resident.

The home's policy, Environmental Cleaning and Cleaning of Equipment, dated August 2010, stated that all resident care equipment must be cleaned and disinfected prior to use and between each use and the DOC stated that it was the home's expectation that lifts are cleaned and disinfected between residents.

Failure of staff to clean and disinfect the lift after contact with a resident increased the risk of infectious disease transmission.

Sources: Observation, staff interviews, Environmental Cleaning and Cleaning of Equipment Policy.
[740884]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, was implemented.

Rationale and Summary
A. The IPAC Standard for Long-Term Care Homes indicated under section 10.2 (c) that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks.

On a day in April 2024, it was observed that residents were not assisted to perform hand hygiene before lunch. A staff member confirmed that residents were not assisted to perform hand hygiene before their lunch meal and the home’s IPAC Lead stated that that there are gaps in the hand hygiene program around dining.

Failure for staff to assistance residents with hand hygiene prior to their lunch meal increased the risk of infectious disease transmission.

Sources: Observation, staff interviews, Hand Hygiene Policy, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023). [740884]

The licensee failed to implement the IPAC Standard for Long-Term Care by not performing hand hygiene after resident/resident environment contact.

Rationale and Summary
B. The IPAC Standard for Long-Term Care Homes indicated under section 9.1 (b) that, at a minimum, Routine Practices shall include hand hygiene after resident/resident environment contact.

On a day in April 2024, during a lunch meal observation, it was observed that a staff member did not perform hand hygiene after assisting a co-worker reposition a resident in their wheelchair.

The home's Hand Hygiene Policy requires that hand hygiene be performed by all staff before and after each contact with a resident or contact with environmental surfaces near the resident.

The staff member confirmed that they did not perform hand hygiene after assisting a co-worker reposition a resident and prior to doing another task.

Failure of staff to complete hand hygiene after contact with a resident increased the risk of infectious disease transmission.

Sources: Observation, staff interviews, Hand Hygiene Policy, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023).
[740884]

WRITTEN NOTIFICATION: Infection Prevention and Control

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 failed to evaluate the Infection Prevention and Control Program at least annually, as required.

Rationale and Summary
A program evaluation was not completed for the Infection Prevention and Control (IPAC) Program in 2023, as required.

An email received on a day in April 2024, confirmed that the IPAC Program evaluation was not completed in 2023. Further, the DOC confirmed that the IPAC Program Evaluation was not completed in 2023.

Failure of the licensee to evaluate the IPAC Program at least annually, as required, could have led to an increased risk of infectious disease transmission.

Sources: Email from staff and DOC interview.
[740884]