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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 11, 2024
Inspection Number: 2024-1493-0004
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	**Inspector Digital Signature**
Meghan Redfearn (000765)	
Additional Inspector(s) Jonathan Conti (740882)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 10-14, 2024, June 18-21, 2024, and June 24, 2024.

The following intake(s) were inspected:
- Intake #00112215- Complaint with concerns regarding skin and wound care and continence care and bowel management for a resident.
- Intake #00112868/Critical Incident (CI) #2994-000010-24- related to falls prevention and management.
- Intake #00113262- Complaint with concerns regarding falls prevention and management, resident care and support services, food, nutrition and hydration, and resident and family councils for a resident.

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- Intake #00114812/CI #2994-000015-24 - related to falls prevention and management.

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

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(c) the implementation of interventions to mitigate and manage those risks

The licensee failed to implement the interventions ordered to mitigate and manage a resident's identified nutritional risks. Specifically, the licensee failed to provide a specific meal item during meal service for a resident.

Rationale and Summary
As reviewed by a Registered Dietitian (RD), a resident had a medical history that required specific nutritional interventions. As a result, the plan of care for the resident was updated with interventions to promote nutritional intake at meals, including being provided a specific meal item at specified meal times. This information was available to staff when serving meals as outlined in the resident dietary profiles.

During a meal service, it was noted that the resident did not receive their meal interventions as per their plan of care. The resident confirmed they were not offered a specific meal item with their meal as outlined in their plan of care. The RD was made aware.

During meal services on two separate dates, the specific meal item was provided to the resident.

Sources: Interviews with a resident and staff; observations of meal service; a resident's clinical record.
[740882]

Date Remedy Implemented: June 12, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 77 (1) (f)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) includes a choice of snacks in the afternoon and evening; and

The licensee failed to ensure that the Spring/Summer 2024 snack menu included a choice of snacks in the afternoon (PM) and evening (HS). Specifically, prior to a specified date, the snack menu only displayed the offering of one choice for PM and HS snacks.

Rationale and Summary
The snack menu in place as of a specified date, only listed assorted cookies as a snack option at PM snack, and only one alternating available snack option for HS snacks.

During a Joint Family and Resident Council Meeting, there was discussion that snack cart options should offer more variety. The manager for laundry and food services (FSM) acknowledged that the snack menu used by staff only indicated one option at each PM and HS snack.

On a specified date, it was noted that a choice of snack was not offered to the residents. This was brought forward to the attention of the FSM.

At a later date, the Spring/Summer 2024 snack menu on the cart was updated to include two snack options for both PM and HS snacks. On two separate dates, it was noted that two snack options were available on the cart and being offered to

residents during PM snack service.

Residents may have experienced limited options when the licensee failed to include a choice of PM and HS snacks on the menu.

Sources: Interviews with a resident, the FSM, and staff; observations snack service; Spring/Summer 2024 menu approval; Spring/Summer 2024 snack menus; family and resident council meeting minutes.
[740882]

Date Remedy Implemented: June 20, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee failed to include the diet extensions list in its process to ensure that food service workers and other staff assisting residents were kept aware of a resident's therapeutic diet requirements.

Rationale and Summary
On a specified date, a resident was assessed by a RD to require a therapeutic modified diet with a modified texture based on their medical diagnoses. Staff identified that dietary staff are to refer to the therapeutic menu (also called diet extensions list), notes on the serving area, and the Long-Term Care (LTC) Resident

Diet Profiles list when providing meals.

On a specified date, it was noted that a resident was not provided their therapeutic diet as per their plan of care. Both the dietary staff and the FSM acknowledged that the meal reference items should have been present for meal service on the specified date.

A RD acknowledged that not providing a therapeutic modified diet as per the menu may have posed an increased risk for altered lab values for the resident.

The FSM updated the serving area with the current diet extensions list for the current menu. A dietary staff member was noted to have the list for reference during meal service on a specified date.

When the licensee failed to ensure that the diet extensions list was used by the dietary staff during meal service, there was a posed risk of staff not being aware of a resident's dietary requirements.

Sources: Interviews with staff, the FSM, and a RD; observations of meal service; a resident's plan of care; diet extensions list for Spring/Summer 2024 menu. [740882]

Date Remedy Implemented: June 12, 2024

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

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.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to them as specified in their plan related to a falls intervention.

Rationale and Summary
A resident's plan of care indicated that they use a falls intervention at all times. The resident was assessed as an increased risk for falls. The intervention was put in place to prevent falls injury.

On a specified date, the resident was observed without the falls intervention in place. A staff member confirmed that the falls intervention was not in place. On another date, the resident was observed without the falls intervention in place. Another staff member confirmed that the resident did not have the falls intervention in place.

Staff acknowledged if the falls intervention was listed in the resident's plan of care, then it should be implemented.

There was a potential risk of falls injury when the resident did not have their falls intervention in place.

Sources: A resident's plan of care; observations of resident; interviews with staff. [000765]

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1) The licensee has failed to ensure that skin audits were documented as indicated in a resident's plan of care.

Rationale and Summary
A resident's plan of care indicated skin audits be completed as required using the appropriate audit tool and be signed off on the resident’s treatment administration record (TAR). Staff were ordered to assess and document as required.

There were no audit tools documented for ten dates between specific dates for the resident. The resident's TAR was signed off as completed for all the unaccounted-for dates except for one date.

Staff were unable to locate the audit tools for the unaccounted-for dates.

There was a risk that skin audits had not been completed when the audit tools were not documented.

Sources: A resident's plan of care; wound audits; interview with staff.
[000765]

2) The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented related to a turning and repositioning task.

Rationale and Summary
A task on a resident's electronic record indicated that they be turned and repositioned as required and that it be documented each shift. The shifts listed under the task included evening shift, 1400 hours to 0000 hours, and night shift, 0000 hours to 0800 hours. There was no option for day shift listed. As a result, turning and repositioning was not being documented during day shift, between 0800 hours and 1400 hours.

A staff member confirmed that there was no turning and repositioning task on the electronic record for the resident on day shift.

There was a potential risk that the resident would not receive turning and repositioning during day shift when there was no task listed in the electronic record.

Sources: A resident's plan of care; interviews with staff; observation of tasks. [000765]

3) The licensee failed to ensure that the provision of care set out in the plan of care for a resident regarding identified tasks was documented on all shifts during a specified timeframe.

Rationale and Summary
A resident's plan of care required staff to assist them with and encourage independence with identified tasks and document it in their clinical record.

The resident's clinical record was reviewed for specific months and indicated that several shifts missed documentation of care provided for the resident regarding the identified tasks.

Staff stated the resident would often refuse assistance and complete tasks independently. The expectation was that staff document on each shift whether the resident completed care on their own, if staff aided, or if care was refused and the gaps in documentation could mean that care was not provided or offered.

Failure to document the provision of care related to identified tasks put the resident at potential risk not receiving or being offered assistance as per their plan of care.

Sources: Interviews with a resident and staff; a resident's clinical record.
[740882]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure that the duties for cleanliness of the equipment were followed. Specifically, the home failed keep a resident's mobility device clean and sanitary.

Rationale and Summary
According to the DOC and staff, mobility device cleaning was scheduled weekly and was to be completed by night staff.

The resident's mobility device was observed to have an unclean appearance on

multiple dates. The resident confirmed that staff had not cleaned their mobility device since receiving it.

As per the posted cleaning schedule for mobility devices, the resident's mobility device was to be cleaned on specific dates. The DOC acknowledged that the resident's mobility device was not cleaned as scheduled and identified that there was no cleaning record for the resident's mobility device available.

There posed a risk to the sanitation of the resident's mobility device when it was not cleaned as per the cleaning schedule.

Sources: Observations of the resident's mobility device; mobility device cleaning schedule; interviews with a resident, staff, and the DOC; the resident's plan of care; Policy and procedure for mobility device cleaning guidelines.
[740882]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee failed to ensure that the home's organized program of maintenance services maintained the condition and state of repair of a resident's room.

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Rationale and Summary
The homes program for maintenance services required a maintenance request form to be submitted to complete repairs to the home, including cosmetic repairs to resident rooms.

A resident's room was observed to not be in a state of good repair on specified dates. The room had multiple areas of damage throughout. The resident stated some of the damages had been there for several years.

The manager of environmental services confirmed they did not have maintenance request forms regarding the damages for the resident's room. They also acknowledged that they were aware of the damages in the resident's room and needed to review them with the DOC to initiate repairs, as they were noted to be cosmetic repairs.

The DOC acknowledged that the damages to the resident's room meant the home was not kept in a good state of repair.

Sources: A resident's room observations; observation of maintenance log; interviews with a resident, staff, the DOC, and the manager of environmental services; Environmental services manual procedures; a resident's plan of care.
[740882]

WRITTEN NOTIFICATION: Care conference

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that a care conference with the interdisciplinary team providing resident care was held at least annually to discuss the plan of care and other matters of importance to a resident and their substitute decision maker (SDM). Specifically, no annual care conference was held for a resident in the year 2023.

Rationale and Summary
On a specified date, a resident's family requested an annual care conference to be held, however a review of the resident's clinical record contained no documentation of one occurring. The resident confirmed that a care conference did not occur in 2023 to their recollection.

The DOC acknowledged that while care conferences for residents occurred in 2023, the resident did not have an interdisciplinary care conference as it was not set up by the staff responsible for doing so at the time. The DOC indicated that a care conference, if it had occurred, would be documented in the resident clinical record, and this was confirmed to not be the case for the resident.

Sources: Interviews with a resident and the DOC; a resident's plan of care.
[740882]

WRITTEN NOTIFICATION: General requirements

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

1) The licensee has failed to ensure that the Continence Care and Bowel Management program in the home was evaluated and updated at least annually.

Rationale and Summary
On a specified date, the home's Continence Care policy was reviewed. The policy was observed to be outdated. As a result, the home's Continence Care and Bowel Management program annual evaluation was requested from the DOC. The DOC was unable to provide records of the Continence Care and Bowel Management program evaluation from 2023.

The DOC stated an annual evaluation had not been done yearly. They also stated they had never seen a Continence Care and Bowel Management program evaluation in the home.

Not completing an annual evaluation of the program posed a risk that the program and its policies would not contain up-to-date information.

Sources: Continence Care policy and procedures; interview with the DOC.
[000765]

2) The licensee has failed to ensure that the Skin and Wound program in the home was evaluated and updated at least annually.

Rationale and Summary
On a specified date, the home's Skin and Wound policies were reviewed. All of the policies provided were observed to be outdated. As a result, the home's Skin and Wound program annual evaluation was requested from the DOC. They were unable to provide records of the Skin and Wound program annual evaluation from 2023.

The DOC stated they did not complete an evaluation of the Skin and Wound program last year. They also stated that the policies provided were the most recent and had not been revised yet.

Not completing an annual evaluation of the program posed a risk that the program and its policies would not contain up-to-date information.

Sources: Skin and Wound policies; interview with the DOC.
[000765]

3) The licensee has failed to ensure that the Falls Prevention and Management program in the home was evaluated and updated at least annually.

Rationale and Summary
On a specified date, the home's Falls Prevention and Management policy was reviewed. The policy was observed to be outdated. As a result, the home's Falls Prevention and Management program evaluation was requested from the DOC. They were unable to provide records of the Falls Prevention and Management program evaluation from 2023.

The DOC stated an annual evaluation had not been done yearly. They stated they had never seen a Falls Prevention and Management program evaluation in the home.

Not completing an annual evaluation of the program posed a risk that the program and its policies would not contain up-to-date information.

Sources: Fall Prevention and Management policy; interview with the DOC. [000765]

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound after they exhibited altered skin integrity. Specifically, the resident did not receive a new skin breakdown assessment when a newly identified skin alteration occurred on a specified date.

Rationale and Summary
On a specified date, staff identified that a resident had an area of skin breakdown to their body. The plan of care indicated wound care was done, however no further information was identified regarding the skin breakdown assessment.

The DOC and staff confirmed that the New Skin Breakdown progress note tool for identifying new skin breakdown was not used, as per policy, when the staff cared for the resident.

There was a posed risk that the resident's newly identified skin breakdown was not properly assessed when staff failed to use the homes clinically appropriate tool.

Sources: Interview with staff and the DOC; a resident's clinical record; the homes Skin and Wound Care program.
[740882]

WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at

least weekly.

Rationale and Summary
A resident's plan of care indicated that staff assess their wound weekly and document on the weekly assessment note. A staff member stated weekly skin assessments were documented in the resident's plan of care. The resident's weekly skin assessments were not observed in their plan of care for three separate weeks.

A staff member stated that if there was no documentation for the weekly skin assessments on those dates, then they were likely not completed. The DOC was unable to provide written documentation that weekly assessments were completed on those dates.

Prior to and after the dates the resident's wound was improving. There was a risk that the resident's wound would not have received appropriate intervention when it was not assessed for three separate weeks.

Sources: A resident's plan of care; interview with staff and the DOC.
[000765]

WRITTEN NOTIFICATION: Skin and wound care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while

asleep if clinically indicated; and

The licensee has failed to ensure that a resident was turned and repositioned every two hours as required.

Rationale and Summary
A resident's plan of care indicated they be turned every two hours as required. Staff stated that the resident was dependent on staff for movement.

Observations were made on separate dates. The resident was not turned and repositioned as required. On each date, staff acknowledged that the resident had not been repositioned as per their plan of care.

There was potential risk that the resident would have worsening skin impairment when they were not repositioned every two hours.

Sources: A resident's plan of care; Turning Schedule policy; observations of turning and repositioning; interviews with staff.
[000765]

WRITTEN NOTIFICATION: Medication management system

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee had failed to comply with ensuring registered staff used best practice standards for documentation required for informed consent of medication being discontinued. Specifically, registered staff did not implement their policy regarding discontinuation of medication.

Rationale and Summary
As per the homes' policy titled "Discontinued Medications- 4-10", last revised September 2019, the nurse processing the discontinued order is to complete the required documentation, which included signing and dating the prescriber's order form to indicate that informed consent from the resident or substitute decision maker was obtained regarding the medication change.

A resident returned to the home from hospital with orders for pain management with a specific medication, but it was ineffective for the resident. Staff obtained new orders for pain management, and it was documented as effective.

The resident's prescriber order form for the changes to pain medication did not have the consent section signed as completed, and the resident's clinical record did not have documentation that informed consent was obtained. Staff acknowledged that consent was not documented.

As a result, the licensee failed to implement the required documentation procedures for consent for the discontinuation of medication, which posed a risk that the resident or substitute decision maker were not adequately informed of the changes.

Sources: Interviews with the DOC and staff; a resident's clinical record; Medical Pharmacies Pharmacy Policy and Procedure Manual.
[740882]

WRITTEN NOTIFICATION: Resident records

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
Documentation indicated that a resident requested a meeting with the physician and that the resident's family be present for the physician's rounds to review their plan of care. There was no documentation by the physician in the resident's electronic or physical records to identify that this had occurred, what the results of the meeting were, or if resident or family concerns were addressed.

Documentation of the physician's visit indicated that staff informed the physician of the family's requests for changes to the plan of care. The physician was noted to make a change to the plan of care, and that for further adjustments, the physician would make a call to the family. Staff left a message for the family regarding the change and indicated that the physician would follow up. There was no documentation within the resident's records to identify that the physician followed up with the family or what the results were for further adjustments.

The DOC and staff confirmed that physician documentation regarding the above occurrences was not noted. Staff indicated documentation may have been taken but was not kept in the written record for the resident.

Sources: Interview with a resident, the DOC, and staff; a resident's clinical record; physician communication binder.
[740882]