Ontario

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: February 23, 2024	
Inspection Number: 2024-1493-0001	
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 Cathy Fediash (214)	**Inspector Digital Signature**
Additional Inspector(s) Emily Robins (741074)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 26, 29, 30, February 7, 8, 9, 12, and 13, 2024.

The following intake(s) were inspected:

- Intake: #00100946 - Critical Incident (CI) #2994-000014-23 related to falls prevention and management.
- Intake: #00106258 -Complaint related to Whistle-blowing protection; Residents' and Family Councils and Resident care and Support services.

The following intake was completed in this inspection:

- Intake: #00107052 - CI #2994-000003-24 - related to falls prevention and management.

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

Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
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: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's plan of care regarding their capacity, was clear.

Rationale and Summary

An assessment completed by an external assessor had identified that the resident was incapable of managing a specified area in their life.

A review of the resident's written care plan indicated the resident had been deemed incapable.

An interview with the DOC confirmed the resident's plan of care was not clear when it had not identified the specified area of incapacity.

When the care plan was not clear, it had the potential for not recognizing the resident's ability to make specified decisions.

Remedy taken before conclusion of the inspection:

The resident's electronic care plan was revised to reflect their specified area of incapacity.

Sources: An external assessment result document, a resident's plan of care plan, and an interview with the DOC.

Date Remedy Implemented: February 13, 2024.
[214]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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.

The licensee failed to ensure that a resident's plan of care was reviewed and revised to include an unavailable intervention, in their falls management plan.

Rationale and Summary

The home submitted a Critical Incident Summary (CIS) for a resident for a fall that caused injury to the resident, for which the resident was taken to the hospital and resulted in a significant change in their health status.

A review of the resident's electronic falls care plan indicated the resident was to have a fall intervention applied at all times.

An observation of the resident with Personal Support Worker (PSW) staff present, identified the resident did not have the fall intervention in place.

PSW and Registered staff indicated the fall intervention had been ordered, but had not yet been delivered to the home.

Registered staff and the Director of Care (DOC) confirmed the resident's plan of care had not been reviewed and revised to identify the delay of this falls management intervention.

When the plan of care was not reviewed and revised to identify the delay in implementing an intervention, this had the potential for delaying the implementation

of a substitute intervention; the potential for harm to the resident as the intended intervention was not being provided and also had the potential to result in inaccurate communication to the staff who provided direct care to the resident.

Remedy taken before conclusion of the inspection:

Registered staff updated the resident's electronic care plan to identify the falls intervention was currently awaiting delivery.

Sources: the CIS report, resident's plan of care, and interviews with PSW staff, Registered staff and other staff.

Date Remedy Implemented: January 29, 2024.
[214]

WRITTEN NOTIFICATION: Complaints procedure-licensee

NC # 002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (a)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;

The licensee failed to ensure that there were written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with the complaints.

Rationale and Summary

Section 108 of the Ontario Regulation 246/22 specified that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with. This regulation also specified that for those complaints that could not be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complied with paragraph 3.

A review of the licensee's policy for reporting and managing complaints (LTC-03-02-01, and dated October 2014), was conducted.

The policy identified a complaint as written or spoken statements of dissatisfaction with the care and services of staff members of the home. The policy had not specified written or verbal complaints as those concerning the care of a resident, independent of staff members of the home and had not included that complaints may be in regards to the operation of the home, as described in section 108 of the Ontario Regulation 246/22.

The policy had also not specified how those complaints that could not be investigated and resolved in 10 business days, would be addressed, and managed, as described in section 108 of the Ontario Regulation 246/22.

An interview with the Chief Executive Officer (CEO) and DOC, confirmed the complaint policy had not incorporated all of the requirements set out in section 108 of the Ontario Regulation 246/22.

When the complaint policy does not include the above requirements as identified in

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the legislation, this has the potential to result in unclear communication of what constitutes a complaint, which could result in information not being communicated to the licensee to address. When the policy does not include how the home manages complaints that could not be investigated and resolved within 10 business days, this has the potential for miscommunication as the person who placed the complaint may not be aware the licensee requires more time to investigate their complaint.

Sources: the licensee's reporting and managing complaints policy (LTC-03-02-01, dated October 2014), and an interview with the CEO and DOC.
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WRITTEN NOTIFICATION: Required information

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 85 (3) (q)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(q) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;

The licensee failed to ensure that the following required information was posted in the home: the most recent minutes of the Family Council meetings.

Rationale and Summary

The Family Council meeting minutes included a form that the council used to communicate with the home. The most recent Family Council minutes were observed to have been posted; however, had not included the communication form.

The Family Council Liaison confirmed that these communication forms were received by the home. They also indicated that while they had been posted when they were originally received, they were not posted currently.

Sources: Observations of the most current family council postings, Family Council Communication forms, and an interview with the Family Council Liaison. [741074]

WRITTEN NOTIFICATION: Licensee must comply

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to ensure they complied with the conditions to which the licence was subject, when a resident had a significant change in their health status.

The Long-Term Care Home Service Accountability Agreement (LSSA) with Ontario Health, pursuant to the Connecting Care Act, 2019, required the licensee to meet the requirements of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) tools, including the RAI-MDS 2.0 User Manual and the RAI-MDS practice requirements.

The LSSA specified the licensee was to:
• conduct quarterly assessments of residents, and all other assessments of residents required by the RAI-MDS tools, using the RAI-MDS tools.
• ensure that the RAI-MDS tools were used correctly to produce an accurate assessment of the resident's RAI-MDS data.
• acknowledge that if used incorrectly, the RAI-MDS tools could increase funding

beyond that to which the controlling shareholders (if any), directors, officers, employees, agents, volunteers, and other representatives (HSP) would otherwise be entitled. The HSP will therefore have systems in place to regularly monitor, evaluate, and where necessary correct the quality and accuracy of the RAI-MDS data.

The RAI-MDS 2.0 User Manual, Canadian Version, February 2012, indicated that any significant change in a resident's condition, either decline or improvement, must be reassessed along with resident assessment protocols (RAPs) by the interdisciplinary care team by the 14th day following the determination that a significant change in status had occurred.

Criteria for determining a significant change in status was identified in the RAI-MDS 2.0 User Manual as:

A "significant change" is defined as a major change in the resident's health status that:

• Is not self-limiting;
• Impacts on more than one area of the resident's health status; and
• Requires interdisciplinary review and/or revision of the care plan.

Rationale and Summary

The home submitted a CIS for a resident for an incident that caused injury, a transfer to hospital and which resulted in a significant change in their health status.

A review of the resident's RAI-MDS assessments indicated a significant change in status assessment for the above incident, had been initiated on a specified date that

was 61 days following their readmission to the home.

An interview with the RAI MDS Coordinator indicated they had become aware of the need to conduct a significant change in status assessment for the resident when they were preparing to conduct their next scheduled assessment. The RAI MDS Coordinator and the DOC confirmed the resident's significant change in status assessment had not been conducted within the timelines identified in the RAI-MDS 2.0 User Manual, which was a condition of the licensee to do so.

When the resident's status is not assessed in the required timelines, there is a potential for risk of harm, as interventions may not be implemented to assist the resident in meeting their highest practicable level of physical, mental and psychosocial well-being.

Sources: a critical incident report , the resident's MDS-RAI assessments; The Resident Assessment Instrument (RAI) RAI-MDS 2.0 User Manual, Canadian Version, February 2012; the licensee's LSAA, and interviews with the DOC and RAI MDS Coordinator.
[214]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 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 failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, revised September 2023, was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) Additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal, and disposal.

Two PSW staff were observed entering a resident's room to deliver items in the resident's bed space area. The resident was on droplet contact precautions at the time. One staff was wearing eye protection and a medical mask but no gown, N95 respirator, or gloves. The second staff was wearing a medical mask, but no eye protection, N95 respirator, gown, or gloves.

Both PSWs acknowledged the resident was on droplet contact precautions at the time of the observation and that they did not wear full PPE when dropping off personal items in the resident's room. The DOC who was covering for the IPAC Lead at the time indicated that both staff members should have been wearing full PPE.

Failure to comply with the IPAC standard, specifically, failure to appropriately select and apply PPE, may have increased the risk of infectious disease transmission.

Sources: Observation of two PSW staff, interviews with both PSW's and the DOC. [741074].