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

Public Report

Report Issue Date: June 10, 2025
Inspection Number: 2025-1493-0003
Inspection Type: Critical Incident
Licensee: Niagara Ina Grafton Gage Village
Long Term Care Home and City: Niagara Ina Grafton Gage Village, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4, 5, 6, 9, 10, 2025.

The following intake(s) were inspected:

·Intake: #00145679 - Critical Incident System (CIS) #2994-000005-25 - related to Improper/Incompetent treatment or care of a resident.

·Intake: #00148273 - CIS #2994-000010-25 - related to Improper/Incompetent treatment of a resident.

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

a) The licensee has failed to ensure that an allegation of improper treatment or care to a resident, was reported immediately, when the incident was not reported until two days later.

Sources: a CIS report , and an interview with the Director of Care (DOC).

b) The licensee has failed to ensure that an allegation of improper treatment or care to a resident, was reported immediately, when the incident was not reported until three days later.

Sources: a CIS report, and an interview with the DOC.

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that an alleged incident of improper care to a resident, was documented in their clinical record, including any immediate assessment(s) of the resident or interventions implemented following the incident.

Sources: a CIS report ; a resident's progress notes, assessments, interviews with two Registered Nursing staff.

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