



**Inspection Report
under the *Long-Term
Care Homes Act, 2007***

**Rapport d'inspection
prévues le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ème} étage
Hamilton ON L8P 4Y7

**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

Telephone: 905-546-8294
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Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 1 and 3, 2011	2011_141_2741_31Jan124440	H-00184 Complaint

Licensee/Titulaire
Grace Villa Limited, 284 Central Avenue, London, ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée
Grace Villa Nursing Home, 45 Lockton Crescent, Hamilton, ON L8V 4V5

Name of Inspector(s)/Nom de l'inspecteur(s)

Sharlee McNally, LTC Inspector #141

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection received in the Hamilton Service Area Office January 20, 2011.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, physiotherapist, registered staff, Personal Support Workers, and residents.

During the course of the inspection, the inspector: observed the resident, reviewed resident file, reviewed the homes investigation notes, internal incident reports, policies and procedures of pain, transferring and incident documentation.

The following Inspection Protocols were used during this inspection:

- Prevention of Abuse, Neglect and Retaliation
- Critical Incident Response
- Pain
- Personal Support Services

Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN
1 VPC
1 CO: # 001

NON- COMPLIANCE / (Non-respectés)
Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régleur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *LTC Homes Act, 2007*, S.O 2007, c. 8, s.3(1)4

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Findings:

1. An identified resident was not cared for by the home in a manner consistent with her needs. The resident sustained injuries causing transfer to hospital and a change in status.

Inspector ID #: #141

WN #2: The Licensee has failed to comply with *LTC Homes Act, 2007*, S.O 2007, c. 8, s.6(10)(b)

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

Findings:

1. An identified resident, with diagnosed injuries, did not have assessments and reassessments of identified symptoms of the injuries completed to meet the resident care needs.

Inspector ID #:

Additional Required Actions

CO # - #001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with <i>LTC Homes Act, 2007, S.O 2007, c. 8, s.6(1)(c)</i>	
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.	
Findings:	
1. An identified resident's written plan of care did not give clear direction related to skin and mouth care.	
Inspector ID #:	#141
Additional Required Actions:	
VPC - pursuant to the <i>Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2)</i> the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that there is a written plan of care for each resident that sets out the planned care, the goals of care and clear directions to staff, to be implemented voluntarily.	

WN #4: The Licensee has failed to comply with <i>LTC Homes Act, 2007, S.O 2007, c. 8, s.6(8)</i>	
The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.	
Findings:	
1. An identified resident's current plan of care was not in printed version to provide immediate and convenient access to all staff.	
Inspector ID #:	#141

WN #5: The Licensee has failed to comply with O. Reg. 79/10, s.30(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.	
Findings:	
1. An identified resident, with changes in frequency and dosage of pain medication administration, did not have assessments or reassessments completed at the time of changes in the interventions.	
Inspector ID #:	#141

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s.34(1)(a)	
Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures	



Findings:

1. An identified resident did not have mouth care provided at a frequency that met the resident's care needs.

Inspector ID #: #141

Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.

Title:

Date:

Date of Report: (if different from date(s) of inspection).

[Handwritten Signature]
May 31, 2011



Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	<input type="checkbox"/> Licensee Copy/Copie du Titulaire	<input checked="" type="checkbox"/> Public Copy/Copie Public
Name of Inspector:	Sharlee McNally	Inspector ID # #141
Log #:	H-00184	
Inspection Report #:	2011-141-2741-31Jan124440	
Type of Inspection:	Complaint	
Date of Inspection:	February 1, 2011	
Licensee:	Grace Villa Limited, 284 Central Avenue, London, ON N6B 2C8	
LTC Home:	Grace Villa Nursing Home, 45 Lockton Crescent, Hamilton, ON L8V 4V5	
Name of Administrator:	Lynette Tyler	

To Grace Villa Limited, you are hereby required to comply with the following order by the date set out below:

Order #:	001	Order Type:	Compliance Order, Section 153 (1)(b)
Pursuant to: <i>LTC Homes Act, 2007, S.O 2007, c. 8, s.6(10)(b)</i>			
<p>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</p>			
<p>Order: The licensee shall prepare, submit and implement a plan to meet the requirements to ensure residents' who have symptoms of injury are assessed and their plans of care reviewed and revised when the care needs change. The plan is to be submitted by May 11, 2011 to Compliance Inspector: Sharlee McNally, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, Fax 905-546-8255</p>			
Grounds:			
<ol style="list-style-type: none"> 1. An identified resident, with diagnosed injuries, did not have assessments and reassessments of identified symptoms of the injuries completed to meet the resident care needs. 			



Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

This order must be complied with by: May 11, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
 c/o Appeals Clerk
 Performance Improvement and Compliance Branch
 Ministry of Health and Long-Term Care
 55 St. Clair Ave. West
 Suite 800, 8th floor
 Toronto, ON M4V 2Y2
 Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

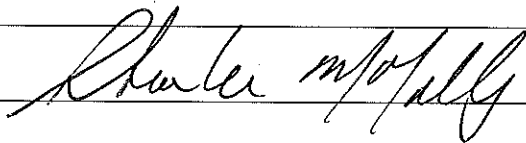
The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
 Attention Registrar
 151 Bloor Street West
 9th Floor
 Toronto, ON
 M5S 2T5

Director
 c/o Appeals Clerk
 Performance Improvement and Compliance Branch
 55 St. Claire Avenue, West
 Suite 800, 8th Floor
 Toronto, ON M4V 2Y2
 Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 6 day of May, 2011.

Signature of Inspector: 



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Direction de l'amélioration de la performance et de la conformité

Name of Inspector:	Sharlee McNally #141
Service Area Office:	Hamilton Service Area Office