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

Rapport d'inspection prévue 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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
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119, rue King Ouest, 11iém étage
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	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 3, 4, 18, 2010	2010_168_2741_03Nov133435	Complaint H-01955

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)
Lisa Vink #168

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection regarding injuries the resident sustained at the home.

During the course of the inspection, the inspector spoke with: the Administrator, Director of Care, and front line nursing staff.

During the course of the inspection, the inspector: Reviewed the residents clinical record as well as the homes copy of their internal investigation

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

[3] WN
[2] VPC
[1] CO

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur 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 LTCHA, 2007, S.O. 2007 c.8, s 24(1)2
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.

Findings:
1. An identified resident sustained an injury in October 2010. The resident was eventually transferred out to the hospital a few days later as a result of the injury and need for immediate treatment. The licensee did not inform the Director of this situation and inaction of staff, for which a resulted in harm to the resident, until seven days after the initial injury, via the submission of a Critical Incident Report.

Inspector ID #:	168

Additional Required Actions:
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed of abuse or neglect of a resident that resulted in harm to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s 3(1)3
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff.

Findings:
1. An identified resident sustained injuries in October 2010, due to an accident. Personal Support Staff were immediately aware of the incident and provided some assistance to the resident. The Registered Staff did not assess the resident for this injury until the following day and treatment was not provided for another day. The staff failed to take action, when the resident was injured, which jeopardized the health and well being of the resident, which is considered neglect.

Inspector ID #:	168

Additional Required Actions:

CO # 001 will be served to the licensee on November 24, 2010

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 50(2)(b)(ii)
Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Findings:
1. An identified resident sustained an injury in October 2010. This injury was first documented by the registered staff the following day. The resident did not receive treatment to this injury or a documented assessment of this injury for another day. Medical support was not involved until the second day at which time the ordered treatment, was not administered to the resident before his transfer to hospital on the following day. The resident with altered skin integrity did not receive immediate treatment or interventions as required in an effort to promote healing and prevent infection.

Inspector ID #:	168

Additional Required Actions:
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who exhibits altered skin integrity receives immediate treatment and interventions as appropriate, to be implemented voluntarily.

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.** [signature] - November 24-2010
Title:	**Date:**	**Date of Report:** (if different from date(s) of inspection).

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
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Ministère de la Santé et des Soins de longue durée
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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

	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Lisa Vink	**Inspector ID #**	168
Log #:	H-01955		
Inspection Report #:	2010_168_2741_03Nov 133435		
Type of Inspection:	Complaint		
Date of Inspection:	November 3, 4, 18, 2010		
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: LTCHA, 2007, S.O. 2007 c.8 s. 3(1)3

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff.

Order:

The licensee shall prepare, submit and implement a plan for achieving compliance to meet the right that residents are not neglected by the licensee or staff. This plan is to be submitted to Inspector: Lisa Vink at lisa.vink@ontario.ca .

Grounds: An identified resident sustained an injury in October 2010. The resident was not assessed for this injury until the following day and treatment was not provided until day 3. The staff at the home failed to take action in this situation in a timely fashion which is considered neglect	
This order must be complied with by:	November 30, 2010

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.

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

Issued on this 24 day of November, 2010.	
Signature of Inspector:	[signature]
Name of Inspector:	Lisa Vink
Service Area Office:	Hamilton Service Area Office