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: October 4, 2023

Inspection Number: 2023-1235-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Grace Villa Limited

Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2023.10.18 11:13:54 -04'00'

Additional Inspector(s)
Betty Jean Hendricken (740884)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16 - 18, 21 - 25, 28 - 31 and September 1, 5 - 7, 2023

The following intake(s) were inspected:

Intake: #00090625 - CI - 2741-000025-23 – Safe and secure home.
Intake: #00091880 - Complaint regarding staff training and care standards.
Intake: #00092482 - Complaint regarding staff training and care standards.
Intake: #00093377 - Complaint regarding resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary:
The plan of care for the resident specified care related to toileting and bathing that was not applicable to the care needs of the resident.

When the plan of care does not provide clear direction to staff, there is risk that staff may not provide the care required to meet the resident's needs.

Sources: Resident's Care Plan, Kardex, Bowel and Bladder Assessment, interviews with staff.

[741071]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to ensure that the home's falls prevention and management program was followed, specifically where staff were required to complete Head Injury Routine (HIR) monitoring as specified for 72 hours.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that the home has in place a falls prevention and management program which includes the monitoring of residents, and that it is complied with.

Staff did not comply with the policies 'Fall Prevention & Management Program - Falls Risk Factors & Related Interventions' and 'Head Injury Routine'.

Rationale and Summary:
A resident experienced an unwitnessed fall.

The homes Falls Prevention and Management Program policy states that post fall, the registered staff will initiate a Head Injury Routine (HIR) for any resident who receives a blow to the head either from a fall, including all unwitnessed falls, or personal injury, using the Head Injury Routine Monitoring Record.

Under the homes HIR policy, residents are to be checked initially then every 15 minutes x four, then every hour x two and every four hours x six for a total of 13 checks. The resident was documented to have received only five of the required HIR checks.

Upon review of the homes policies, the Director of Care (DOC) confirmed that the policies were not followed.

By not completing the HIR as required by policy, there is a risk that if the resident experienced adverse effects related to an unwitnessed fall, that they would have gone unnoticed.

Sources: Resident's progress notes, Fall Prevention & Management Program - Falls Risk Factors & Related Interventions policy, Head Injury Routine policy and interview with the DOC.

[741071]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that when a resident exhibited altered skin integrity, that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

Rationale and Summary:
The resident was documented to have altered skin integrity.

Upon review of the resident's progress notes, Medication Administration Record (MAR), Treatment Administration Record (TAR) and assessments, there was no documented skin and wound assessment

nor was there documented treatment for resident's wound areas.

The DOC confirmed that a weekly skin and wound assessment should have been completed when the resident presented with new wounds, but an assessment was not done.

There is risk that by failing to complete a wound care assessment as required, that the resident's wounds were not treated accordingly.

Sources: Resident's progress notes, MAR, TAR, assessments and interview with the DOC.

[741071]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)

The licensee failed to ensure that where they are required to make a report immediately under subsection (1) and it is after normal business hours, that the report was made using the Ministry's method for after hours emergency contact.

Rationale and Summary:
A Critical Incident occurred in the home which required immediate reporting to the Ministry. As per the Critical Incident Report (CI), the home became aware of the incident at 0515h, and the Ministry was first notified at 1207h that same day.

The DOC confirmed that it was the responsibility of the registered staff working at the time to notify the Ministry.

There was no risk to the resident because of this.

Sources: CI #2741-000025-23, interview with DOC.

[741071]

WRITTEN NOTIFICATION: Emergency Plans

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. viii.

The licensee failed to ensure that the home's Emergency Plan for a missing resident was followed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place an emergency plan for a missing resident, and that the plan is complied with.

Specifically, staff did not comply the homes Code Yellow plan.

Rationale and Summary:
The home's Code Yellow plan states that the first staff member to identify a missing resident is to report to the nurse on the unit the resident is from, and that all staff must check the unit they are working on.

According to the home's investigation notes, this was not completed when a staff member found a resident was not in their room during rounds.

The DOC confirmed that the staff member was expected to look for the resident, notify the registered staff and call a Code Yellow.

As a result of not following the homes Code Yellow plan for a missing resident, the resident fell and sustained injury.

Sources: Homes investigation notes, Executive Director's notes, Code Yellow plan, and interview with the DOC.

[741071]

COMPLIANCE ORDER CO #001 Bathing

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Ensure that the two identified residents receive bathing by their preferred method at a minimum twice a week.
2. If the residents are unable to receive bathing by their preferred method on a given day, it must be documented as to why, the strategies taken to complete the bathing, and the alternative actions taken.

3. Until October 31, 2023, complete daily audits of Point of Care (POC) and Point Click Care (PCC) documentation related to the residents' bathing for accuracy and completeness, maintaining a record of the staff member(s) completing the audits, the dates and times of the audits, audit findings and any corrective action taken in relation to the findings of the audits.

Grounds

The licensee has failed to ensure that two residents were bathed, at a minimum, twice a week by the method of their choice.

A. Rationale and Summary:
A resident's plan of care stated that their preference for bathing was showers and the resident reported to inspector #741071 that they prefer showers.

According to POC documentation, the resident received one shower over a 20-week period and had otherwise received bed baths. In a review of the resident's progress notes, there was one documented refusal of care during that time.

The Associate Director of Care (ADOC) reported that they were not aware the resident was not receiving showers and that the expectation is that if a resident receives a bed bath instead of a shower, that the registered staff are notified, this is documented in PCC and the ADOC is notified.

As a result of not following the homes procedures, the resident did not receive their preferred method of bathing as per their plan of care.

Sources: Resident's Kardex, Care Plan, POC documentation, progress notes, interviews with the resident and the ADOC.

[741071]

B. Rationale and Summary:
A resident's plan of care stated that the resident prefers a bath or shower.

Staff stated that the resident cannot be showered because the home does not have a shower chair that suits the needs of the resident, therefore the resident receives bed baths.

According to POC documentation, the resident received one shower over a seven-week period and had otherwise received bed baths. There was no documentation in the resident's progress notes related to bathing during that time.

The ADOC stated they were not aware that the resident was not being showered due to not having a shower chair to meet their needs. The ADOC confirmed that the expectation is that if a resident receives a bed bath instead of a shower, that the registered staff are notified, this is documented in PCC and the ADOC is informed.

As a result of not following the homes procedures, the resident did not receive their preferred method of bathing as per their plan of care.

Sources: Resident's Kardex, POC documentation, progress notes, interviews with staff and the ADOC.

[741071]

This order must be complied with by

October 31, 2023

COMPLIANCE ORDER CO #002 Transferring and Positioning Techniques

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Educate all direct care staff on safe transferring techniques.
2. Keep a written record of the education provided, the dates training occurred, names of staff members who attended, and the name of the person who provided the training.
3. Until December 8, 2023, complete daily audits of POC documentation related to the three identified residents' transferring and bed mobility for accuracy and completeness, maintaining a record of the staff member(s) completing the audits, the dates and times of audits, audit findings and any corrective action taken in relation to the findings of the audits.

4. Until December 8, 2023, complete twice weekly random visual audits of transfers and bed mobility across all shifts for the three residents. Maintain a record of the dates and times of the audits, name of staff member(s) completing the audits, audit findings, and any corrective measures taken in relation to the findings of the audits.

Grounds

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting three identified residents.

A. Rationale and Summary:
A resident's plan of care for Bed Mobility stated two-person physical assistance.

A staff member acknowledged that on an unspecified day, they repositioned the resident by themselves using the bed pad.

Not ensuring safe transferring and positioning techniques are used when repositioning residents may result in an injury to the resident.

Sources: Resident's Kardex, Care Plan, POC documentation and interview with staff.

[741071]

B. Rationale and Summary:
A resident’s plan of care for Bed Mobility stated two-person physical assistance.

A staff member acknowledged that on an unspecified day, they turned the resident by themselves using the bed pad.

Not ensuring safe transferring and positioning techniques are used when turning residents may result in an injury to the resident.

Sources: Resident's Kardex, Care Plan, POC documentation and interview with staff.

[741071]

C. Rationale and Summary:
A resident's plan of care for Transfers stated they required a two-person transfer with a mechanical lift.

A staff member acknowledged independently transferring the resident using a mechanical lift.

There was risk of injury to resident when staff independently transferred the resident using a mechanical lift.

Sources: Resident's Care Plan, the homes Dispute Resolution Form and interview with staff.

[741071]

This order must be complied with by

December 8, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP 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, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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