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
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Original Public Report

Report Issue Date: May 2, 2024	
Inspection Number: 2024-1235-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Grace Villa Limited	
Long Term Care Home and City: Grace Villa Nursing Home, Hamilton	
Lead Inspector Waseema Khan (741104)	Inspector Digital Signature Waseema Khan Digitally signed by Waseema Khan Date: 2024.05.28 10:02:43 -04'00'
Additional Inspector(s) Barbara Grohmann (720920) Lisa Vink (168)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15, 16, 17, 18, 19, 22, 23, 24, 2024
The inspection occurred offsite on the following date(s): April 22, 2024

The following intake(s) were completed in this complaint inspection:

- Intake: #00112515 - Complaint with concerns regarding staffing
- Intake: #00109787 -Complaint with concerns regarding resident neglect.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00103229 - Critical Incident(CI) #2741-000062-23 -related to prevention of abuse and neglect.

- Intake: #00103895 - Critical Incident(CI) #2741-000064-23 -related to falls prevention and management. .
- Intake: #00107351 - Critical Incident(CI) #2741-000004-24 - related to falls prevention and management.
- Intake: #00109008 - Critical Incident(CI) #2741-000006-24- related to falls prevention and management;
- Intake: #00109659 - Critical Incident(CI) #2741-000008-24- related to falls prevention and management
- Intake: #00109881 - Critical Incident(CI) #2741-000009-24- related to falls prevention and management;

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

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)
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 has failed to ensure that the plan of care set out clear directions to the staff who provided care to resident.

Rationale and Summary
A resident required extensive to total assistance from two or more staff to complete their care needs.

The frontline staff use Kardex, part of plan of care, to obtain information to provide resident care.

A review of plan of care and Kardex at that time showed that for resident's personal care, they required one person physical assist with supervision to limited assistance.

As per the Long-Term Care Home staff the plan of care was unclear to the staff.

The ED and ADOC acknowledged the importance of updating the plan of care / Kardex when resident's care needs had changed.

Sources: Resident clinical records; interviews with the ED, ADOC, RAI coordinator and other staff. [720920]

WRITTEN NOTIFICATION: Care and Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (3)
Nursing and personal support services
s. 11 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the

regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The licensee has failed to ensure that at least one registered nurse (RN) was on duty and present in the home at all times.

Rationale and Summary
The Employee Services Coordinator (ESC) stated that they prepared the schedules in advance and put copies on each floor for the RNs to update if there were any sick calls or no-shows. The staff schedule for a day in March 2024 indicated that during day shift (0630-1430 hours), RN was to schedule as the nurse in charge of the building and RN was scheduled to work on the third floor.

The updated schedule showed that both RN and were crossed off and registered practical nurse (RPN) was indicated as "nurse in charge" of the building. Employee call-in forms specified that both RN's had called in sick for their day shift on a day in March, 2024 due to illness with no staff identified as their replacement.

RPN verified that RPN was serving as "nurse in charge" during day shift and that there was no RN in the home at that time, either from an agency or from the management team. The ESC explained that while that has occurred, it was not the preferred practice.

Failure to have an RN on duty and in the home at all times may have resulted situations where treatment and/or services were delayed that only an RN could perform.

Sources: March 2024 staff schedule, employee call-in forms; and interviews with staff. [720920]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect resident from abuse by another resident .

Rationale and Summary
The definition of physical abuse includes the use of physical force by a resident that causes physical injury to another resident.
On a day in December 2023, two residents were involved in an incident which included physical and verbal aggression.
Resident sustained an injury as a result of the actions of another resident.
Failure to protect resident from abuse by another resident resulted in an injury.

Sources: Review of risk management, progress notes and assessments of residents, review of video footage of the incident, interview with the Registered Practical Nurse (RPN) and other staff. [168]

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 35 (3) (d)
Nursing and personal support services
s. 35 (3) The staffing plan must,

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

The licensee has failed to ensure that the required back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work was consistent with the Act.

Rationale and Summary
Fixing Long-Term Care Act (FLTCA), 2021 subsection 11 (3) specified that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

The home's contingency plan for registered staff indicated that if there was no RN in the building and a RPN was in charge, the on-call manager must be notified and a nursing back-up would be assigned from the nursing management team so the RPNs could call and speak with a RN from the management time at any time required during the shift.

A review of the staff schedule for on a day in March, 2024 showed that both RN's called in sick and were replaced with RPN who served as "nurse in charge" for the day shift (0630-1430 hours). The ESC explained that while that was not the preferred practice, it has occurred. RPN verified that not only was an RN not present in the home during the day shift on a day in March, 2024, there have been other instances when an RPN was put in charge when a scheduled RN(s) have called in sick, especially on weekends.

The Executive Director confirmed that the provided contingency plan was currently in place.

Failure to ensure that the nursing back up plan was consistent with the FLTCA may have resulted in times where at least one RN was not present in the home.

Sources: March 2024 staff schedule, employee call-in forms, Contingency plan for registered staff (June 2023); interviews with the ED and other staff. [720920]t

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246 / 22, s. 53 (2).

The Licensee has failed to comply with the requirement to provide for assessment instruments under home's Pain Assessment Program.

Rationale and Summary
In accordance with O. Reg 246 / 22, s.11 (1) (b), the home's Pain Assessment Program directs the nursing staff to screen the residents with presence of pain using, Pain Assessment in Advanced Dementia (PAINAD) scale for residents who were cognitively impaired.

RPN confirmed when a resident expressed pain, pain assessment were to be completed and documented in Point Click Care (PCC). Resident experienced pain to

their limb on three specified dates in February 2024; however, pain assessments were not completed.
RN verified that when pain was identified, pain assessments are required to be completed in PCC.

Specifically, staff did not comply with the completion of PAINAD scales when the resident experienced pain.

There was a moderate risk of harm to the resident when staff did not comply with the home's policy.

Sources: Resident's clinical records, Pain Assessment Program, Home's investigation notes, Interviews with RPN and RN. [741104]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246 / 22, s. 54 (1).

The licensee has failed to comply with monitoring of resident after they had an unwitnessed fall on a day in February 2024.

In accordance with O. Reg 246 / 22 s. 11 (1) (b), the licensee is required to ensure that

there is a fall prevention and management program that provides strategies to mitigate falls, including the monitoring of residents, and must be complied with.

Specifically, staff did not comply with the policy "Head Injury Routine" which was included in the licensee's Fall Prevention and Management Program.

Rationale and Summary
The home's Head Injury Routine (HIR) policy directed registered staff to complete a neurological flow sheet in Point Click Care (PCC) in order to monitor vital signs, pupil size, motor response, verbal response and level of consciousness of the resident, following a specific time schedule. The policy specified that after the initial neurological flow sheet, one was to be completed every 15 minutes for an hour, every 30 minutes for two hours, every hour for four hours, and once a shift for three consecutive shifts, for a total of 32 hours.

Resident had an unwitnessed fall on a day in February 2024 at 1250. Between when the resident was found at 1250 hours and 2347 hours, only six neurological flow sheets were completed in PCC. After the initial neurological flow sheet, a second one was completed 25 minutes later, and the following four were completed at two hour intervals.

The ADOC explained the importance of following the HIR schedule as outlined in the home's policy to identify any changes in the resident's condition related to a possible head injury after an unwitnessed fall. The ED acknowledged that the neurological flow sheets completed in PCC were not done as per the home's policy.

Failure to complete the neurological flow sheets as required may have resulted in staff not identifying complications from an unwitnessed fall related to a head injury.

Sources: Resident's clinical records, Head Injury Routine policy (January 2024); interviews with the ED, ADOC, and other staff. [720920]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that, resident who demonstrated responsive behaviours, actions taken to respond to the needs of the resident, which included assessments and interventions and the resident's responses to interventions were documented.

Rationale and Summary
On a day December 2023, resident was involved in an incident where they displayed verbal and physically aggression towards a co-resident.
Registered Practical Nurse (RPN) identified that immediately after the incident was reported they attempted to speak with the resident; however, they would or could not answer questions and that the intervention of staff monitoring was initiated.
The RPN confirmed that they failed to document their assessment, interventions or the resident's response.
Failure to document actions taken to respond to the needs of the resident resulted in incomplete records.

Sources: Review of progress notes and risk management report for resident and interviews with RPN and other staff. [168]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed, no later than one business day, after an incident that caused injury to two residents, which resulted in a significant change in their health condition.

Rationale and Summary
A. A resident had two unwitnessed falls in February 2024. They were sent to the hospital post-second fall. the next day the home was updated by the hospital that the resident had a significant change in condition post-hospital admission.

The home failed to update he Director within one business day.

B. A resident sustained a fall and was sent out to the hospital on a day in February 2024. The same day of the admission to the hospital, the resident's SDM alerted the

home that resident will require a surgical intervention with significant change in condition of the resident.

The home failed to report the incident to the Director within one business day.

Failure to send a CI within the required time frame may have resulted in the Director not being made aware of the situation and taking actions if necessary.

Sources: Resident's clinical records; interviews with the Executive Director and other staff. [720920]