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: July 17, 2025

Inspection Number: 2025-1235-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Grace Villa Limited

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3, 4, 7-11, 14-17, 2025.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00148239, CI 2741-000019-25 was related to allegations of neglect,
- Intake: #00148304, CI 2741-000014-25 was related to allegations of abuse; and,
- Intake: #00148893, CI 2741-000018-25 was related to an injury of unknown cause.

The following intakes were inspected in this complaint inspection:

- Intake: #00147414 was related to Resident's Bill of Rights, menu planning, meal service, and maintenance services,
- Intake: #00148189 was related to Resident's Bill of Rights, personal care and continence care and bowel management; and,
- Intake: #00149016, was related to Residents' Bill of Rights and complaint investigation.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Safe and Secure Home
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 clear direction was provided to staff providing care to a resident when the transfer logo in their room indicated they required a different sling for transfers and than the one indicated in their Kardex.

The logo in the resident's room was observed to be updated to align with the

Kardex.

Sources: observation of a resident's room, interviews with staff, resident's clinical records.

Date Remedy Implemented: July 16, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) 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; or

The licensee has failed to ensure that a resident's plan of care was fully revised when their assistance needs changed. A quarterly assessment indicated their level of assistance changed related to transfers and mobility. The Resident Assessment Instrument (RAI) Coordinator acknowledged that the information captured in the resident's quarterly assessment was not reflected in their plan of care and updated the applicable areas.

Sources: resident's clinical records and interview with RAI Coordinator.

Date Remedy Implemented: July 9, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure a resident had the right to care and services consistent with their needs when they were not provided timely assistance by two staff members for toileting when the staff prioritized resident rounds over assisting the resident to the toilet.

Sources: interview with staff, resident's progress notes and plan of care, home's investigation notes.

The licensee has failed to ensure a resident had the right to care and services consistent with their needs when a staff member did not assist the resident after they requested assistance for transporting them in their wheelchair.

Sources: home's investigation notes, video recording of incident, interview with staff.

WRITTEN NOTIFICATION: Licensee must Investigate, Respond and Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee

knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that allegations of abuse of a resident, communicated to Social Worker (SW), was immediately investigated. The Director of Clinical Services (DOCS) acknowledged that the investigation six days after the accusations were made, when it was communicated to the management team by the SW.

Sources: resident's clinical records, home's investigation notes; interviews with the SW and DOCS.

WRITTEN NOTIFICATION: Care Conference

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six week following their admission. A resident's care conference was held on nine weeks after their admission. The Director of Programs and Support Services (DPSS) explained that they took over the role of scheduling care conference after issues with meeting the six week time frame was identified by the home. They acknowledged that multiple residents had

their care conferences nine to 11 weeks after their admission date. No documentation was identified in the resident's clinical records that the day or time of the care conference needed rescheduling.

Sources: resident's clinical records, Care Conference Schedule; interviews with the DPSS and Director of Care.

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program was followed for a resident when they experienced new pain and their pain was not assessed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a pain management program to identify pain in residents and manage pain, and that it was complied with. Specifically, staff did not comply with the Pain Management policy, which required staff to complete a pain assessment tool when a resident experienced new pain.

Sources: resident's clinical records, policy 005300.00(e) Pain Assessment Program, interview with DOCS, home's investigation notes.

WRITTEN NOTIFICATION: Records

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times when the SW created a late entry progress note detailing a complaint from the resident's family. The information was documented three weeks after the allegations were made, and the note was back dated. The SW acknowledged that they did not contemporaneously document the family member's claims.

Sources: resident's clinical records; and interview with SW.