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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Public Report

Report Issue Date: December 19, 2025
Inspection Number: 2025-1235-0011
Inspection Type: Other Critical Incident
Licensee: Omni Quality Living (Southwest) Limited Partnership by its general partner Omni Quality Living (Southwest) GP Ltd.
Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 10, 16, 18-19, 2025

The following intake(s) were inspected:
-Intake: #00161954 - related to medication administration.
-Intake: #00164720 - Other: Compliance Order CO#001 : FLTCA, 2021, s. 154 (1) 2. Non-compliance with: O. Reg. 246/22, s. 102 (2) (b) Infection prevention and control program.

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

Written policies and protocols for the medication management system were not implemented by staff, related to dispensing, storage, and administration of drugs used in the home.

A) The home's Narcotic and Controlled Medication Counts policy stated that all monitored drugs must be counted together at every shift change by two nursing staff, one coming on shift and one going off shift.

Two registered staff did not count the controlled medications together at shift change.

Sources: interview with staff; the home's policy.

B) The home's medication administration policy stated that pre-pouring of medications was not allowed and that staff were to handle only one resident's medication at a time.

A registered staff dispensed medication for three different residents into one medicine cup at the same time.

Sources: Critical Incident (CI) report; the LTC home's investigation records; staff interviews; the home's policy.

C) The home's medication administration policy directed staff to sign for medications after they were administered to a resident.

A registered staff signed in advance that medication was administered to three residents, however, the medications were not provided to the residents.

Sources: Resident clinical records; CI report; the LTC home's investigation records; staff interviews; the home's policy.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

A medication cart was left unlocked and unattended.

Treatment carts were left unlocked and unattended on three occasions. The treatment carts contained bottles of Proviodine Solution 10% that was identified on the label as poisonous if ingested.

Sources: observations; staff interview.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Controlled substances were stored in the top drawer of a medication cart and were not kept in a separate locked box within the medication cart.

Sources: CI report; the LTC home's investigation records; staff interviews; the home's policy.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

Three residents were prescribed a medication and the medication was not administered to the residents as specified by the prescriber.

Sources: resident clinical records; CI report; the LTC home's investigation records; staff interviews; the home's policy.