

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: May 7, 2026

Inspection Number: 2026-1235-0003

Inspection Type:

Proactive Compliance Inspection

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 dates: April 29, 30, 2026 and May 1, 4, 5, 6 and 7, 2026.

The following intake was inspected #00176931, a Proactive Compliance Inspection.

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

- Medication Management
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

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,
(a) the planned care for the resident.

A resident presented with behaviours and interventions were identified and implemented. A review of the care plan, which personal support worker staff had access to did not include the presence of the behaviours nor the interventions in place.

Sources: Review of clinical health records and interview with nursing staff.

WRITTEN NOTIFICATION: Emergency plans

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 90 (1)

Emergency plans

s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with, responding to and preparing for emergencies, including, without being limited to, epidemics and pandemics; and
(b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency.

The licensee was required to ensure that their emergency plan for code white was complied with. The procedure included strategies to prevent code white, that staff were to complete a Broset Violence Checklist when a resident had a change in

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behavior or increased agitation.

A resident demonstrated increased agitation and staff did not implement a Broset or other monitoring tools until five days later.

Sources: Review of Code White – Violent/Aggressive Behaviour, the resident's record and interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)

Responsive behaviours

s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,

(a) integrated into the care that is provided to all residents.

A resident presented with behaviours. The physician was notified and orders were received. The behaviour continued and the physician was again notified, a new medication was ordered as well as a referral to specialized services. It was not until the specialized services assessed the resident that screening tools and assessments of possible behavioural triggers, as required in O. Reg. 246/22 s. 58 (1) 1, were initiated.

Sources: Review of clinical health record and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control.

A registered staff was observed applying gloves prior to administering a medication to a resident without washing their hands, after the medication was administered the staff removed their gloves and did not wash their hands prior to completing other duties.

Sources: Observation of a medication administration pass and discussion with registered staff.