Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 26, 2016	2016_342611_0007	003885-16	Resident Quality Inspection

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT HAMILTON ON L8V 4V5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KELLY CHUCKRY (611), IRENE SCHMIDT (510a), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 23, 24, 25, 26, 29, March 1, 2, 3, 4, 8, and 9, 2016

Other inspections conducted concurrent with this RQI included: Critical Incident (CI) inspections #004793-14, #016511-15, and 020170-15 related to falls, complaint inspections #006703-14 related to falls, #017690-15 related to assessments and documentation, #033980-15 related to falls and personal care, #035002-15 related to nutrition and food quality and #035442-15 related to personal care.

During the course of the inspection, the inspectors toured the home, reviewed health records, policies and procedures, home's internal investigation notes, and observed resident care and dining and snack service.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), Environmental Services Manager (ESM), Food Service Supervisor (FSS) dietician, Physiotherapist, Ward Clerk, registered staff, Personal Support Workers (PSW's), dietary staff and recreation staff. In addition, residents and family members were interviewed as part of this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 3. (1)	CO #001	2015_323130_0004	611
LTCHA, 2007 s. 3. (1)	CO #005	2015_323130_0004	611

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #040 was observed during stage one of the RQI to have multiple dressings to their extremities. On an identified date, the resident complained to the Inspector of having pain to their extremities.
A review of the clinical record indicated resident #040 was cognitively alert. A review of the annual Resident Assessment Protocol (RAP) for an identified time period, indicated the resident had a high risk for skin breakdown.

On an identified date, a referral for social work was submitted and the Registered Social Worker (RSW) spoke with the resident. The RSW asked what pain level they had and the resident indicated a numeric pain score. The RSW documentation further indicated that they believed the resident's mood had changed because of the constant pain.

On an identified date, resident #040 returned from a specialist appointment. A review of the eMar for that time period indicated the resident complained of pain and was provided pain medication on three identified dates. One of those dates the pain medication was charted as ineffective.

An interview with staff #114 and #115 indicated the resident had not received a pain assessment when the resident returned to the home from a specialist appointment or when the Social Worker had indicated the resident's mood changed due to their constant pain. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

The home circulated the 2015 Resident Satisfaction Survey starting in March 2015. An interview conducted with the President of Residents' Council confirmed that the home did not seek the advice of council in the development of the questions contained in the satisfaction survey. This was further confirmed by review of the 2015 Residents' Council minutes.

An interview with staff #116 and the DOC confirmed that the home did not seek the advice of Resident's Council in the development of the questions contained in the residents satisfaction survey. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A review of the plan of care for resident #043 indicated they had been admitted on an identified date, with a history of a specified infection and a high risk for falls. Interventions were specified in the plan of care. On an identified date, the resident had exhibited signs and symptoms of an infection and the physician had ordered a diagnostic test. Further review of the clinical record for a two month period of time indicated the resident continued to exhibit resistive behaviours and decreased fluid intake which required the resident to be on multiple fluid watch assessments. On two identified dates, the resident sustained a fall. The second fall resulted in a transfer to hospital where the resident was treated for an injury. A review of resident #043's clinical record did not indicate a diagnostic test was completed as ordered.

An interview with the DOC confirmed the care set out in the plan of care, identified as the order by the physician for a diagnostic test, was not provided to the resident as specified in the plan.

B) A review of resident #043's plan of care indicated the resident was at a high risk for falls and would attempt to self transfer from their wheelchair to their bed. The medication the resident was prescribed had the potential to further affect their gait and balance. An intervention in the resident's plan of care was identified for the staff to not leave the resident in their wheelchair next to their bedside as they would attempt to transfer. On an identified date, a Registered Practical Nurse (RPN) documented they were in the hallway completing a medication pass when they heard the resident yelling for help. The staff and writer had entered into room and the resident was found on the floor sitting up on their buttocks, between the wheelchair and the bed. A summary of the Fall Risk Assessment completed at the time of the fall identified the resident was to have required hands-on assistance to move from place to place.

An interview with the DOC confirmed the care set out in the plan of care was not provided to the resident as specified in the plan of care when the resident, while in their wheelchair, was identified as being located beside the bed when the fall had occurred. [s. 6. (7)]

2. The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

Resident #031 was admitted to the home on an identified date, and was assessed as a high risk for falls. Some of their medications had the potential to further affect their gait, balance and judgment. Documentation included that the resident would also walk throughout the facility unassisted and used their wheelchair when outside the facility. The resident was assessed to show slight memory loss and was determined to be capable of making their own decisions. The resident's plan of care identified fall prevention interventions and a goal to remain free of falls. Despite these interventions the resident experienced their first fall on an identified date. They had three more falls in the subsequent month, and the plan of care was updated. No new interventions were identified. The resident fell again from their wheelchair and was sent to hospital with an injury. The resident continued to be a high risk for falls and at the time of inspection the

resident experienced multiple falls from their date of admission. The resident's plan of care identified interventions that were all implemented shortly after admission, and did not contain new or different approaches when the care set out in the plan had not been effective.

An interview with staff #106 confirmed that through their recent analysis of the resident's falls, the resident's current interventions as identified in the plan of a care, had not been effective when they continued to have multiple falls. A review of the resident's Post Fall Audit Tool reports indicated the continued approach with the resident's current fall prevention program.

An interview with the DOC confirmed that different approaches had not been considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan had not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #031 was admitted to the home on an identified date. The resident walked throughout the facility unassisted and had a mobility device which they used when inside and outside the facility. The DOC identified that there was a doctor's order that the resident had ground privileges, and casual leave of absence with continuation of medications and treatment with supervision of a responsible party for up to 48 hours.

An interview with the DOC and a review of the clinical record indicated the resident was capable of making their own decisions, and identified a risk when the resident did not follow the directions for supervision or a responsible party when outside of the facility.

An interview with staff member #108 indicated the resident was known to independently leave the facility, without supervision of a responsible party. An incident occurred on an identified date outside of the home. The resident sustained an injury during this incident. A review of the resident's clinical record did not include the documentation of the assessed risk to the resident when they left the home independently and unsupervised. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A) A review of the clinical record for resident #047, revealed documentation of three separate complaints reported.

A review of the home's complaint log revealed no documentation of these complaints. The DOC confirmed the home had not kept a documented record of these complaints. (510a)

B) A complaint was made to the home on an identified date from resident #043's family member. A review of the home's Client Service Response and Resolution Form for this time period was not completed in it's entirety omitting the: Action taken, recommendations to prevent reoccurrence, outcome, attempts to contact family and a brief summary of the discussion.

An interview with the DOC confirmed they had contacted the family member on several occasions but had not completed the documented record used to identify the response provided to the complainant and a description of their response. (511) [s. 101. (2)]

Issued on this 3rd day of May, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.