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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2017_704682_0011	023755-17	Complaint

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

AILEEN GRABA (682), GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 6, 7 and 8, 2017.

During this inspection resident's and staff were interviewed, resident care and meal service observed, clinical records and relevant policies and procedures and home investigation files were reviewed.
Please note: The following on site inquiry log# 024198-17 was done concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC) , registered staff, personal support workers (PSW), residents and families.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care was based on an assessment of the resident and the resident's needs and preferences.

A) The plan of care for resident #002 revealed they were at high risk for falls related to their diagnosis. A progress note recorded in the resident's record on an identified date in 2017, revealed they had sustained a fall. The progress note also revealed that an intervention to prevent falls for resident #002 was not implemented at the time of the incident. Staff #100 confirmed in an interview on an identified date in 2017, that the intervention had been implemented prior to the incident. A review of the current plan of care revealed that the need for the intervention was not identified on the written plan of care, which was used to provide direction to the staff providing care. The DOC confirmed on an identified date in 2017, that the resident's plan of care was not based on their assessed needs, specifically related to the need for the intervention to prevent falls for resident #002. (Inspector #130). [s. 6. (2)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) The plan of care for resident #002 revealed they were at high risk for falls related to their diagnosis. A progress note recorded in the resident's record on an identified date in 2017, revealed they had sustained a fall. The progress note also revealed that the intervention in place to prevent falls for residents #002 was implemented at the time of the incident but not in working order. The DOC confirmed in an interview on an identified date in 2017, that it was the expectation that staff ensure that the intervention was in safe working order. They acknowledged that on a identified date in 2017, staff failed to ensure that the intervention to prevent falls was in working order. The home's equipment was not maintained in a safe condition on a identified date in 2017. (Inspector #130). [s. 15. (2) (c)]

WN #3: 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).

Findings/Faits saillants :

1. The licensee 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. O. Reg. 79/10, s. 101 (2).

A) A clinical record review revealed progress notes dated on identified dates in 2017 indicated resident #001's power of attorney (POA) had discussed complaints regarding the care of resident #001 with the DOC. A review of the client service response forms from identified dates in 2017 provided by the home did not include any documentation that included the nature of the verbal complaint, the type of action taken to resolve the complaint, responses or if any follow up action was required for either complaint that occurred on the identified dates in 2017. An interview with the acting Administrator on an identified date in 2017 acknowledged that not all complaints received from resident #001's POA were documented using the client service response forms and the home failed to ensure a record was kept of each verbal and written complaint. [s. 101.(2)] (682)

Issued on this 13th day of February, 2018

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

Original report signed by the inspector.