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 prévue 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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2018	2018_704682_0023	028131-18	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

AILEEN GRABA (682), CATHY FEDIASH (214), LISA BOS (683), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 23, 24, 25, 26, 29, 30, 31, November 1, 2, 7, 8, 9, 13, 14, 15, 16, 19, 2018.

The following onsite inquiries were conducted concurrently with the RQI:
000437-18 related to falls prevention
026097-18 related to prevention of abuse
026250-18 related to missing resident
029705-18 related to prevention of abuse

The following critical incident inspections were conducted concurrently with the RQI:
008734-18, 025868-18, 018497-18, 025132-18, 016680-18, 011022-18 related to falls prevention
026493-18 related to financial abuse

The following complaint inspections were conducted concurrently with this RQI:
004740-18 related to responsive behaviours, prevention of abuse
004519-18 related to responsive behaviours, prevention of abuse
018008-18 related to administration of medication
012680-18 related to prevention of abuse, dealing with complaints, change in condition
018401-18 related to falls prevention, reporting critical incidents, prevention of abuse
017439-18 related to continence, housekeeping, laundry, pest control, availability of supplies, dealing with complaints, nursing/personal support services.

The following compliance order follow up inspections were conducted concurrently with this RQI:
009909-18 related to medication
009945-18 related to prevention of abuse

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Associate Executive Director (AED); Director of Clinical Services (DCS); Associate Director of Clinical Services; (ADCS); Director of Program and Support Services (DPSS); Registered Dietitian (RD); Director of Culinary Services; Resident Assessment Instrument (RAI) Coordinator; Employee Services Coordinator; Physiotherapist, registered staff; personal support workers (PSW); Family Council representative; President of Residents' Council; residents and families.

During the course of the inspection, the Inspectors toured the home; observed provision of care, dining and medication administration, reviewed clinical records; meeting minutes; policies and procedures; Critical Incident System (CIS) submissions; investigation notes, staffing schedules and operational plans.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

O. Reg 79/10, s. 2(1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

O. Reg. 79/10, s. 2(1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review of the home's policy titled "Abuse – Prevention, Elimination and Reporting Policy," effective May 2017, identified the following: "Where abuse of any kind, of a resident by a staff member, is proven to have occurred, disciplinary action will be taken up to and including termination of employment. Any form of abuse is grounds for termination."

A review of Critical Incident (CI) log #026097-18 / 2741-000024-18 identified concerns related to alleged staff to resident #031 abuse. As per the CI, on an identified date, resident #031 expressed concerns regarding care provided by staff #116.

The home's internal investigation notes were reviewed on an identified date in 2018. The notes identified an interview with resident #031 on an identified date in 2018, where they indicated that staff #116 spoke to them and resident #024 in a demeaning manner. The resident identified that they required assistance and staff #116 assisted them. The resident identified that they wanted to be involved in decisions regarding their personal care but was dismissed by staff #116. The investigation notes identified that resident #031 was emotional.

A review of the home's internal investigation notes identified that resident #024 was interviewed on an identified date, regarding staff #116. In the interview, resident #024 identified that staff #116 did not allow them to direct their personal care. A review of the progress notes for resident #025 identified a note on an identified date in 2018, which indicated that the resident reported that staff were not allowing them to participate in directing their care.

In an interview with resident #031 on an identified date in 2018, they identified an occasion where they told staff #116 that they wanted assistance with an intervention, but staff #116 did not assist them. Resident #031 identified that staff #116 did not provide care as per their plan of care. Resident #031 identified that on a following day, they requested assistance by staff #116, but were denied assistance. Resident #031 identified that they expressed their concerns about the care provided by staff #116 to another staff member.

In an interview with the Associate Director of Clinical Services on an identified date in 2018, they acknowledged that statements from both resident #031 and resident #024 supported the allegations.

In an interview with the Executive Director on an identified date in 2018, Inspector #682 read the definitions from O. Reg. 79/10, s. 2(1) for both verbal and emotional abuse and asked the Executive Director if they felt the incident met either definition. The Executive Director identified that they felt the incident met the definition of both verbal and emotional abuse by staff #116 to resident #031.

The home did not ensure that resident #031 was protected from abuse by staff #116. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

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

In an interview with the family council on an identified date in 2018, they could not recall if the Council's advice was sought in developing and carrying out the satisfaction survey, and in acting on its results. A review of the family council meeting minutes on an identified date in 2018, for the year 2018 did not identify documentation of the Council's advice being sought in the development of the satisfaction survey.

In an interview with the Director of Program and Support Services on an identified date in 2018, they acknowledged that the 2018 satisfaction survey was sent out in the late spring or early summer. They did not believe that the family council's advice was sought in developing and carrying out the 2018 satisfaction survey.

In an interview with the Executive Director on an identified date in 2018, they acknowledged that the Family Council's advice was not sought in developing and

carrying out the 2018 satisfaction survey. [s. 85. (3)]

2. The licensee failed to ensure that they documented and made available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

In an interview with the Family Council on an identified date in 2018, they could not recall if the results of the satisfaction survey were documented and made available to the Family Council in order to seek the advice of the Council about the survey. A review of the Family Council meeting minutes on an identified date in 2018, for the year 2018, did not identify documentation of the results of the satisfaction survey being shared with the Family Council.

In an interview with the Director of Program and Support Services on an identified date in 2018, they acknowledged that the home had not yet analyzed the results of the 2018 satisfaction survey as they were still receiving responses. On an identified date in 2018, the Inspector requested documentation that the results of the 2017 satisfaction survey were shared with the Family Council.

In an interview with the Executive Director on an identified date in 2018, they acknowledged that they reviewed the Family Council meeting minutes from 2017, and indicated that they could see that there was an intent for the home's previous Executive Director to present at the Family Council meeting, but they left their position prior to that happening. The Executive Director acknowledged that they could not find any documentation that the results of the satisfaction survey were made available to the Family Council in order to seek their advice about the survey. [s. 85. (4) (a)]

3. The licensee failed to ensure that they documented and made available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

During an interview on an identified date in 2018, the resident council denied that the results of the satisfaction survey were documented and made available to the Resident Council in order to seek the advice of the Council about the survey. A review of the Resident Council meeting minutes on an identified date in 2018 for the year 2018, did not identify documentation of the results of the satisfaction survey being shared with the Resident Council.

During an interview with the Director of Program and Support Services on an identified date in 2018, they acknowledged that the home had not yet analyzed the results of the 2018 satisfaction survey as they were still receiving responses. On an identified date in 2018, the Inspector requested documentation that the results of the 2017 satisfaction survey were shared with the Resident Council.

During an interview with the Executive Director on a identified date in 2018, they acknowledged that there was an intent for the home's previous Executive Director to present at the Resident Council meeting, but they left their position prior to that happening. The Executive Director stated that they could not find any documentation that the results of the satisfaction survey were made available to the Resident Council in order to seek their advice about the survey. [s. 85. (4) (a)]

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 Family Council in developing and carrying out the satisfaction survey, and in acting on its results; to ensure that they document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey; to ensure that they document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #3: 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out (a) the planned care for the resident.

A review of Critical Incident (CI) log #018497-18 / 2741-000017-18 indicated that on an identified date in 2018, resident #009 was observed to quickly sit down on the floor. On an identified date in 2018, the resident sustained an injury and appeared in pain so the resident was sent to hospital. On identified dates in 2018, resident #009 was observed with a mobility device and a falls prevention intervention in place. A review of the clinical record for resident #009 identified that they were a fall risk. Resident #009's written plan of care identified interventions in place to prevent falls. A review of the written plan of care on an identified date in 2018, did not identify a specific fall prevention intervention for resident #009. In an interview with staff #107 on an identified date in 2018, they acknowledged that resident #009 had a fall prevention intervention in place. In an interview with registered staff #108 on an identified date in 2018, they confirmed that resident #009's fall prevention intervention was not identified in their written plan of care. The home did not ensure that resident #009's written plan of care set out the planned care for the resident related to their fall prevention intervention. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident

that sets out (c) clear directions to staff and others who provide care to the resident.

The licensee submitted a critical incident (CI) log # 025132-18/ 2741-000021-18. The CI indicated that resident #007 sustained a fall on an identified date in 2018, that resulted in an injury. Progress notes indicated that resident #007 was found on the floor on an identified date in 2018. A clinical record review indicated that resident #007 was assessed on identified dates in 2018. Both assessments completed by staff #115 identified resident #007 required specific assistance for transfers. A review of the care plan, last revised on an identified date in 2018, indicated that resident #007 required a specific type of assistance with transfers. During an interview on an identified date in 2018, staff #115 stated that within the same time period, care plan interventions and assessments for transfers were different and that the plan of care did not give clear direction regarding transfer status to staff and others who provide direct care to resident #007. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complimented each other.

A review of the Minimum Data Set (MDS) assessment for resident #004 from identified dates in 2018, identified that the resident had a specific code all or most of the time.

A review of resident #004's clinical record did not identify anything to indicate that they required the specific code during the observation period for the identified dates in 2018, MDS assessment. In an interview with staff #107 on an identified date in 2018, and with resident #004 on a identified date in 2018, they did not recall a time when the resident condition met that specific code. In an interview with registered staff #108 on identified dates in 2018, they did not recall the resident condition meeting that specific code on a identified date in 2018. In an interview with the RAI Coordinator on identified dates in 2018, they identified that the resident did not meet the requirements for that specific code.

The home did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of resident #004 when they were coded with a specific code on an identified date in 2018 and the electronic documentation and staff interviews did not indicate that the resident met that specific code. 6. (4) (a)]

WN #4: 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 has failed to ensure that equipment was maintained in a good state of repair.

On an identified date in 2018, three pieces of equipment were observed to be in a poor state of repair. A gray commode in the tub room was observed with a tear in the seat pad approximately eight centimetres (cm) in length. A blue shower chair in the tub room was observed with a tear in the seat pad covering approximately ten (cm) in length. A gray commode was observed with a tear in the seat pad approximately eight (cm) in length. A follow up observation occurred on an identified date in 2018 and the same three chairs remained unchanged and were observed to be wet from use. The Assistant Executive Director and the Executive Director confirmed they were in a poor state of repair on an identified date in 2018. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters.

On an identified date in 2018 at 1030 hours, windows were observed to open to one meter. The observation was confirmed by the Assistant Executive Director and the Executive Director on an identified date at 1100 hours. [s. 16.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council meeting minutes identified a concern raised at the Family Council meeting on an identified date in 2018. A review of the complaints binder identified client service response forms did not identify a client service response form for the concern.

In an interview with the Executive Director on an identified date in 2018, they acknowledged that they were aware of the concern. They identified that they spoke with head office regarding possible solutions. They acknowledged that they recalled speaking to Family Council about the concern, but acknowledged that a written response was not provided to the Family Council within 10 days of receiving the concern. [s. 60. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The dining observation was completed as part of stage one of the Resident Quality Inspection (RQI) on an identified date in 2018. During the observation, it was identified that there were a number of residents who were observed to be served their whole meal at once.

During a follow up observation on an identiifed date in 2018, residents #018, #019, #020, #021, #022 and #023 were observed to have been served their meal and they were served all courses, which included soup, their main course (a sandwich), their dessert and drinks.

A review of the electronic record for residents #018, #019, #020, #021, #022 and #023 did not identify anything that said to serve all courses together.

In an interview with the Registered Dietitian (RD) on an identified date in 2018, they acknowledged that some residents had it in their care plan to serve all courses together. They identified that if they felt a resident could benefit from being served all courses at once they would add it to their care plan.

In an interview with staff #109 and #111 on identified dates in 2018, indicated that they gave some residents all of their food at once because it was hard to keep them seated. Staff #111 identified that for residents who were served all courses at once, it was identified in their care plans.

In an interview with the Director of Culinary Services on an identified date in 2018, they acknowledged that the care plans for residents #018, #019, #020, #021, #022 and #023 did not identify that they could be served all courses at once.

The home did not ensure that residents #018, #019, #020, #021, #022 and #023 were served course by course service of meals, unless otherwise indicated by the resident or the resident's assessed needs. [s. 73. (1) 8.]

2. The licensee failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating.

The dining observation was completed as part of stage one of the Resident Quality Inspection (RQI) on an identified date in 2018. During the observation, it was identified that staff #109 was feeding resident #016. While staff #109 was feeding the resident, they were observed to not use proper techniques to assist the resident with eating. Staff #109 was also observed to not use proper technique to assist the resident #016 during the meal service. Resident #016 was observed again on a identified date in 2018, and staff #110 was observed to not use proper technique when they were feeding them.

In an interview with the Director of Clinical Services on an identified date in 2018, they acknowledged that staff were using improper techniques when they were feeding them.

In an interview with the Associate Director of Clinical Services on an identified date in 2018, they identified that they went and observed the meal of the home that day and acknowledged that they observed improper technique used by staff while assisting the

residents.

The home did not ensure that staff #109 and #110 used proper techniques while they assisted resident #016 with feeding on identified dates in 2018, respectively. [s. 73. (1) 10.]

3. The licensee failed to ensure that the home had a dining and snack service that included appropriate furnishings in resident dining areas, including dining room tables at an appropriate height to meet the needs of all residents.

A review of the clinical record for resident #008 identified that they were at a nutritional risk, required assistance with eating.

The dining observation was completed as part of stage one of the Resident Quality Inspection (RQI) on an identified date in 2018. During the observation, it was identified that resident #008 required an assistive device.

The resident was again observed on an identified date in 2018, and the assistive device was at the elevated height. On an identified date in 2018, resident #008 was observed with the assistive device to be elevated. On an identified date in 2018, the RD acknowledged that resident #007's assistive device elevated.

The home did not ensure that resident #007 assistive device was at an appropriate height to meet their needs. [s. 73. (1) 11.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007,

c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

On an identified date in 2018, the initial tour of the home was completed as part of the Resident Quality Inspection. Part of this tour included the review of the posting of information. On a bulletin board near the front lobby of the home they had a sign that said Ministry of Health (MOH) Public Reports and under the sign public inspection reports from the year 2017 were posted. Near the front entrance of the home there was a binder labelled "Public Information" which included MOH public inspection reports from the year 2016 and earlier. There were no MOH public inspection reports posted from the year 2018.

In an interview with the Director of Clinical Services on an identified date in 2018, they identified that residents and or families sometimes remove the reports from the bulletin board without returning them and acknowledged that there were other reports from 2018 that were not currently posted.

The home did not ensure that copies of the inspection reports from the past two years for the long-term care home were posted. [s. 79. (3) (k)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements were required to prevent further occurrences and that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home was considered in the evaluation.

On an identified date in 2018, the Associate Director of Clinical Services provided Inspector #683 with a copy of the home's evaluation of their prevention of abuse and neglect program, titled "Quality Management Audit Report Annual Evaluation – Resident Abuse and Neglect Policy," dated May 22, 2018. The evaluation was printed from Surge Learning and included yes and no questions about the home's abuse and neglect policy, yes and no questions about evidence of investigation, analysis of every incident of alleged abuse, notification of the appropriate persons and yes and no questions asked of residents and family about the abuse policy.

In an interview with the Executive Director and staff #117 on an identified date in 2018, they acknowledged that they felt their program evaluation assessed the effectiveness of their policy to promote zero tolerance of abuse and neglect of residents but did not include what changes and improvements were required to prevent further occurrences. Staff #117 acknowledged that APANS Health Services missed the part about the evaluation and improvement of the prevention of abuse and neglect program at some of their homes. The Executive Director acknowledged that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were not considered in the evaluation.

The home did not ensure that at least once in every calendar year, an evaluation was made to determine what changes and improvements were required to prevent further occurrences of abuse, that the results of the analysis undertaken of every incident of abuse or neglect was considered in the evaluation. [s. 99. (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee commenced work without approval of the Director, specifically renovations to the home.

The licensee commenced work without approval from the Director. On an identified date in 2018 the licensee had commenced the installation of a vinyl flooring in the lounge areas. The lounges were not in use during this time and a plastic drape was applied from the floor to the ceiling, however not sealed and extremely penetrable. The television was moved to another location. A copy of the operational plan and Director approval for the renovations was requested by the inspector on an identified date in 2018 and a document was provided on a identified date 2018, however the plan was not dated or signed and there wasn't an approval letter from the Director. The Executive Director confirmed the lack of approval. [s. 305. (3) 1.]

Issued on this 11th day of December, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AILEEN GRABA (682), CATHY FEDIASH (214), LISA BOS (683), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2018_704682_0023
Log No. / Registre no:	028131-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 28, 2018
Licensee / Titulaire de permis :	Grace Villa Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Grace Villa Nursing Home 45 Lockton Crescent, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet West

To Grace Villa Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.
Specifically, the licensee shall ensure that:
1. Resident #031 and all other residents are protected from abuse by anyone.
2. At least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.
3. The results of the analysis undertaken of every incident of abuse and neglect are considered in the evaluation.

The licensee has failed to comply with the following compliance order (CO) #001 from inspection #2018_587129_0004 served on April 23, 2018, with a compliance date of August 28, 2018.

The licensee must be compliant with s. 19(1) of the LTCHA.
Specifically, the licensee shall ensure that:
A written plan for achieving compliance and ensuring that resident #022, resident #031, resident #033, and all other residents, are protected from abuse by co-residents who demonstrate responsive behaviours; is prepared, submitted and implemented.
The plan is to include, but not limited to:
1. The develop and implement a responsive behaviour assessment that includes the identification of possible triggers for the behaviours demonstrated and the identification of the potential risks posed to co-resident when resident #026, resident #032 and any other resident demonstrates responsive behaviours.
2. A schedule for the implementation of the above noted assessment and tools

for resident #026, resident #032 and all other residents demonstrating responsive behaviours.
4. A schedule for the provision of face to face training for all staff who provide direct care to resident #026 and resident #032 that includes;
-What constitutes a responsive behaviour,
-How the above noted assessment and tools are to be utilized, and
-The expectations for the development and the evaluation of the effectiveness of plans of care related to the management of responsive behaviours.
Documentation of the above noted training is to be maintained by the home.
5. A schedule for the implementation of on-going quality monitoring activities related to the completion of the above noted assessment and tools, the development and evaluation of the plans of care to respond to the needs of residents who demonstrate responsive behaviours and staffs compliance with the licensee's policy related to the management of responsive behaviours.

The licensee completed all steps in CO #001.
The licensee failed to comply with section 19 (1).

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it was related to one resident. The home had a level 4 compliance history of a previous CO that included:
• CO issued on January 27, 2016 (2015_250511_0014);
• CO issued on July 9, 2017 (2017_569508_0007);
• CO issued on April 23, 2018 (2018_587129_0004) with a compliance due date of August 28, 2018.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all residents were protected from abuse by anyone.

O. Reg 79/10, s. 2(1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

O. Reg. 79/10, s. 2(1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or

infantilization that are performed by anyone other than a resident.

A review of the home's policy titled "Abuse – Prevention, Elimination and Reporting Policy," effective May 2017, identified the following: "Where abuse of any kind, of a resident by a staff member, is proven to have occurred, disciplinary action will be taken up to and including termination of employment. Any form of abuse is grounds for termination."

A review of Critical Incident (CI) log #026097-18 / 2741-000024-18 identified concerns related to alleged staff to resident #031 abuse. As per the CI, on an identified date, resident #031 expressed concerns regarding care provided by staff #116.

The home's internal investigation notes were reviewed on an identified date in 2018. The notes identified an interview with resident #031 on an identified date in 2018, where they indicated that staff #116 spoke to them and resident #024 in a demeaning manner. The resident identified that they required assistance and staff #116 assisted them. The resident identified that they wanted to be involved in decisions regarding their personal care but was dismissed by staff #116. The investigation notes identified that resident #031 was emotional.

A review of the home's internal investigation notes identified that resident #024 was interviewed on an identified date, regarding staff #116. In the interview, resident #024 identified that staff #116 did not allow them to direct their personal care. A review of the progress notes for resident #025 identified a note on an identified date in 2018, which indicated that the resident reported that staff were not allowing them to participate in directing their care.

In an interview with resident #031 on an identified date in 2018, they identified an occasion where they told staff #116 that they wanted assistance with an intervention, but staff #116 did not assist them. Resident #031 identified that staff #116 did not provide care as per their plan of care. Resident #031 identified that on a following day, they requested assistance by staff #116, but were denied assistance. Resident #031 identified that they expressed their concerns about the care provided by staff #116 to another staff member.

In an interview with the Associate Director of Clinical Services on an identified date in 2018, they acknowledged that statements from both resident #031 and resident #024 supported the allegations.

In an interview with the Executive Director on an identified date in 2018, Inspector #682 read the definitions from O. Reg. 79/10, s. 2(1) for both verbal and emotional abuse and asked the Executive Director if they felt the incident met either definition. The Executive Director identified that they felt the incident met the definition of both verbal and emotional abuse by staff #116 to resident #031.

The home did not ensure that resident #031 was protected from abuse by staff #116. [s. 19. (1)] (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Aileen Graba

Service Area Office /
Bureau régional de services : Hamilton Service Area Office