



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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

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, 11th étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection November 3 & 4, 2010	Inspection No/ d'inspection 2010_168_2741_03Nov113837	Type of Inspection/Genre d'inspection Complaint and Critical Incident H-02079 H-02401 H-02438
Licensee/Titulaire Grace Villa Limited 284 Central Avenue London ON N6B 2C8 Fax 519-672-8729		
Long-Term Care Home/Foyer de soins de longue durée Grace Villa Nursing Home 45 Lockton Crescent Hamilton ON L8V 4V5		
Name of Inspectors/Nom de l'inspecteurs Lisa Vink, #168		
The purpose of this inspection was to conduct a complaint and critical incident inspection. During the course of the inspection, the inspector spoke with: The Administrator, Assistant Director of Nursing, the charge Registered Nurse, front line staff and the resident. During the course of the inspection, the inspectors: Reviewed clinical records, reviewed policies and procedures where relevant, observed care and interviewed staff. The following Inspection Protocols were used during this inspection: Prevention of Abuse and Neglect Fall Prevention		
1 Findings of Non-Compliance were found during this inspection. The following action was taken: [1] WN [1] VPC		

NON-COMPLIANCE / (Non-respectés)



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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

**Rapport
d'inspection prévue
le *Loi de 2007 les
foyers de soins de
longue durée***

Definitions/Définitions

WN – Written Notifications/Avis écrit

VPC – Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Référencement du directeur

CO – Compliance Order/Ordre de conformité

WAO – Work and Activity Order/Ordre de travail et d'activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.)

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b),(c)

The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

- (b) **the resident's care needs change or care set out in the plan is no longer necessary; or**
(c) **care set out in the plan has not been effective.**

Findings:

An identified resident has had recent changes in her physical abilities due to a number of causative factors. In October 2010, the resident fell asleep in an unsafe location for approximately 15 minutes. Staff informed the resident that this was not safe and removed her for her safety.

Later that evening the resident again fell asleep in an unsafe location and the progress notes indicate that she "dropped her hairbrush 4 times as she continuously falls asleep or small period of time".

Later in October 2010, the resident again fell asleep in an unsafe location however this time sustained an injury as a result.

The resident was transferred to the hospital for assessment due to the recent changes in status.

The staff were aware of the changes in the residents status in early October 2010, however her plan of care was not revised to include this change in need, prior to the injury, when the previous interventions set out in the plan were not effective.

Inspector ID #: 168

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 with ensuring that residents are reassessed and the plan of care reviewed and revised with changes in the residents care needs and when the care set out has not been effective, to be implemented voluntarily

Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

**Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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

**Rapport
d'inspection prévu
le *Loi de 2007 les
foyers de soins de
longue durée***

		<i>Review - Dec 7/10</i>
Title:	Date:	Date of Report: (if different from date(s) of inspection).