

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

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
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 11<sup>ième</sup> étage  
HAMILTON ON L8P 4Y7  
Téléphone: (905) 546-8294  
Télécopieur: (905) 546-8255

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| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>No de registre</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|--|---|-----------------------------------|--|
| Dec 23, 2019                                   | 2019_689586_0026                              | 020097-19, 021077-19              | Complaint  |

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**Licensee/Titulaire de permis**

Grace Villa Limited  
284 Central Avenue LONDON ON N6B 2C8

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

Grace Villa Nursing Home  
45 Lockton Crescent HAMILTON ON L8V 4V5

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

JESSICA PALADINO (586)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): December 6, 9, 10 and 11, 2019.**

**The following Complaint Inspections were completed concurrently:**

**021077-19 - Personal Support Services; Falls Prevention; and,  
020097-19 - Falls Prevention.**

**PLEASE NOTE: A Written Notification and Compliance Order related to Ontario Regulation 79/10, s. 8 (1) (b) identified in a concurrent Critical Incident System (CIS) inspection #2019\_689586\_0027 was issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.**

**During the course of the inspection, the inspector(s) observed resident care and reviewed resident health records, internal investigation notes, video footage and policies and procedures.**

**The following Inspection Protocols were used during this inspection:  
Falls Prevention  
Personal Support Services**

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

**1 WN(s)**

**0 VPC(s)**

**1 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

|   |  |
|---|--|
| <p>Legend</p> <p>WN – Written Notification<br/>VPC – Voluntary Plan of Correction<br/>DR – Director Referral<br/>CO – Compliance Order<br/>WAO – Work and Activity Order</p>  | <p>Légende</p> <p>WN – Avis écrit<br/>VPC – Plan de redressement volontaire<br/>DR – Aiguillage au directeur<br/>CO – Ordre de conformité<br/>WAO – Ordres : travaux et activités</p>  |
| <p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

**Inspection Report under  
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Homes Act, 2007****Rapport d'inspection en vertu de  
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1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put into place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 51, the licensee was required to have a continence care and bowel management program.

The licensee's policy, "Bowel & Bladder Program Implementation Policy" (B.3.2, effective date May 2017), indicated that residents should not be left unattended during a particular aspect of care, unless otherwise indicated in the plan of care.

A. According to CIS #2741-000019-19 submitted to the Director, resident #001 was left unattended during care, where they sustained an injury.

The resident's documented plan of care indicated that the resident required two-person assistance and total assistance for the entire process.

According to the home's internal investigation notes, as well as a review of the video footage, and interview with the Police, ED and DOC, it was confirmed that the resident was left unsupervised for an extended period of time.

In an interview with the DOC, they confirmed that the expectation of the home was for staff to stay with the resident. They also confirmed that resident #001 should not have been left unsupervised.

B. During investigation of the above noted CIS, it was identified through review of video footage, that resident #003 was also left unattended at the same time as resident #001. They were assisted by staff members #107 and #108.

The resident's documented plan of care indicated that the resident required extensive assistance using a particular intervention.

In an interview with the DOC, they confirmed that resident #003 was also left unsupervised for an extended period of time as well, and that the resident should have been supervised. [s. 8. (1) (b)]

***Additional Required Actions:***

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

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**Issued on this 3rd day of January, 2020**

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

**Original report signed by the inspector.**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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 Operations Division  
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée  
Inspection de soins de longue durée

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** JESSICA PALADINO (586)

**Inspection No. /**

**No de l'inspection :** 2019\_689586\_0026

**Log No. /**

**No de registre :** 020097-19, 021077-19

**Type of Inspection /**

**Genre d'inspection:** Complaint

**Report Date(s) /**

**Date(s) du Rapport :** Dec 23, 2019

**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

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

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

**Order # /**

**No d'ordre :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,  
 (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and  
 (b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with r. 8 (1) (b) of the O. Reg 79/10.

Specifically, the licensee must:

- 1) Ensure residents #001 and #003, or any other resident requiring monitoring during a particular aspect of care, unless otherwise identified in their plan of care, are not left unattended during that process.
- 2) Ensure staff members #107 and #108 review, with a member of the management team, the licensee's "Bowel & Bladder Implementation Policy" and are provided re-education on the expectations of the home.

**Grounds / Motifs :**

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put into place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 51, the licensee was required to have a continence care and bowel management program.

The licensee's policy, "Bowel & Bladder Program Implementation Policy" (B.3.2, effective date May 2017), indicated that residents should not be left unattended during a particular aspect of care, unless otherwise indicated in the plan of care.



**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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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

A. According to CIS #2741-000019-19 submitted to the Director, resident #001 was left unattended during care, where they sustained an injury.

The resident's documented plan of care indicated that the resident required two-person assistance and total assistance for the entire process.

According to the home's internal investigation notes, as well as a review of the video footage, and interview with the Police, ED and DOC, it was confirmed that the resident was left unsupervised for an extended period of time.

In an interview with the DOC, they confirmed that the expectation of the home was for staff to stay with the resident. They also confirmed that resident #001 should not have been left unsupervised.

B. During investigation of the above noted CIS, it was identified through review of video footage, that resident #003 was also left unattended at the same time as resident #001. They were assisted by staff members #107 and #108.

The resident's documented plan of care indicated that the resident required extensive assistance using a particular intervention.

In an interview with the DOC, they confirmed that resident #003 was also left unsupervised for an extended period of time as well, and that the resident should have been supervised.

The severity of the issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 3 history of non-compliance with this subsection of the Regulation that included:

- Voluntary Plan of Correction (VPC) issued April 23, 2018 (2018\_587129\_0003); and,
- Written Notification (WN) issued April 25, 2019 (2019\_689586\_0004). (586)

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

Feb 05, 2020

**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

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
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2007, chap. 8

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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**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, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of 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](http://www.hsarb.on.ca).

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**Ordre(s) de l'inspecteur**

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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
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2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

**PRENEZ AVIS :**

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale 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 des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 23rd day of December, 2019**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Jessica Paladino

**Service Area Office /**

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