Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 15, 2021	2021_556168_0008	005772-21	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

LISA VINK (168)

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): May 26, 27, 28, 31, 2021 and June 3, 4, 7, 2021 and off site on June 8, 2021.

Please note that this complaint inspection was conducted for log 0057772-21 related to falls prevention and management; nutrition care and hydration programs; plan of care and prevention of abuse and neglect.

Inspector Jennifer Allen was in attendance, to shadow the inspector, for a portion of the inspection.

This inspection was conducted concurrently with a Follow Up Inspection, which included an inspection of previously identified Compliance Order (CO) #001 from inspection 2021_556168_0002 for Ontario Regulation (O. Reg.) 79/10, s 8. (1) related to policies, etc. to be followed, with a compliance due date (CDD) of May 12, 2021 and to CO #002 from inspection 2021_556168_0002 for O. Reg. 79/10, s.131 (2) related to the administration of drugs, with a CDD of April 9, 2021.

An A2 Infection Prevention and Control Program (IPAC) Checklist was completed during this inspection and a Safe and Secure Inspection Protocol to inspect upon cooling requirements.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), corporate Nursing Consultants, associate ED, acting Director of Care (DOC), assistant DOC (ADOC), Food Services Supervisor (FSS), former Registered Dietitian (RD), Physiotherapist (PT), Director of Environmental Services, a Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), pharmacy staff and residents.

During the course of the inspection, the inspector observed the provision of care and services, reviewed records, including but not limited to, clinical health records, complaint records, air temperature logs, policies and procedures and investigative reports.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Reporting and Complaints
Safe and Secure Home

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

- **7 WN(s)**
- **3 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	Légende 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (10) 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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for a resident set out the planned care for the resident.

A staff member documented in the progress notes that staff were to monitor a resident for a specific need, and that this was recorded on the unit record for ongoing monitoring. A review of the care plan did not include the direction for staff to monitor the resident for the specific need.
The planned care related to monitoring was not included in the care plan which all staff had access to.

Sources: Review of the progress notes and plan of care for a resident and interviews with staff. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to a resident.

The RD assessed a resident and increased their prescribed volume of a nutritional supplement on a Prescriber's Digiorder.
Interview with the RD identified that they entered the order into the electronic Medication Administration Record (eMAR).
A review of the eMAR included a different amount of supplement to be administered than the directions recorded on the Presriber's Digiorder.
The resident received an additional amount of supplement until the order was included as part of the Quarterly Medication Review.
The plan of care did not provide clear direction related to the volume of a supplement to be administered.

Sources: Review of Prescriber's Digiorder, Medication Review and eMAR for a resident and interviews with staff. [s. 6. (1) (c)]

3. The licensee failed to ensure that a resident and their substitute decision-maker (SDM) were given the opportunity to participate fully in the development and implementation of the resident’s plan of care.

i. A resident had a change in their medications following a pharmacy consultation.
The clinical record did not include documentation that the resident or the SDM were notified of the change.
ii. A resident's weight record identified that the resident had a weight change.
The RD assessed the resident and orders were received to provide a nutritional supplement.
The RD identified that they discussed the change in condition and proposed treatment with the resident; however, not the SDM until a later date when additional concerns were identified.
The SDM identified that they were not notified by the home of the resident's weight change.
iii. A resident returned from the hospital.
A review of the Re-Admission Order Form identified that a medication was discontinued on their readmission to the home.
The clinical record did not include documentation that the resident or the SDM were notified of this change.

Interview with the SDM identified that they were not informed of the resident's medication change.
iv. A resident experienced a symptom with a specific characteristic.
The resident continued with symptom for a few days, at which time the SDM was notified that the resident had experienced the symptom; however, they were not informed of the identified characteristic of the symptom.
The next day, the SDM was informed that the symptom continued and of the characteristic.
The following day, a discussion was held with the SDM regarding the resident's symptoms, status and goals of care were identified.
The SDM was not given the opportunity to participate fully in the development and implementation of the resident’s plan of care when they were not notified of changes in the resident's condition or treatment.

Sources: Assessments, Prescriber's Digiorder, Re-Admission Order Form and progress notes for a resident and interviews with staff. [s. 6. (5)]

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

i. A resident was assessed and a request was made that they had their weekly weight completed for a period of time.
A review of the record did not include a weekly weight on or around the week after the request was made.
The weight was not obtained as required.
ii. A resident was on a nutritional supplement to be administered at specified times.
The record did not include direction for the supplement to be administered on request, or as needed.
The record included that on a specific date the supplement was given to the resident on request.
The nutritional supplement was not provided as set out in the plan of care.
iii. A resident was prescribed two nutritional supplements.
On a specific date the home did not have one of the two supplements available for administration to the resident.
According to the eMAR progress notes a staff member provided the resident an additional amount of one supplement as the other was not available on the identified date.
The nutritional supplement was not provided as set out in the plan of care.

Sources: Review of the eMAR, assessments, weight records and progress notes for a resident and interviews with staff. [s. 6. (7)]

5. The licensee failed to ensure that the plan of care for a resident was revised when their care needs changed or care set out in the plan was no longer necessary.

A resident was identified in their plan of care at risk for falls.
Observations of the resident noted that they did not have a specific falls intervention nor were bed rails part of their bed system.
A review of the current care plan noted the use of a specific falls intervention and the use of a bed rail.
A review of the eMAR included the use of bed rails.
The plan was not revised with changes in care needs or when the care set out in the plan was no longer necessary.

Sources: Observations of a resident and their room, review of the resident's plan of care and eMAR and interviews with staff. [s. 6. (10) (b)]

6. The licensee failed to ensure that a resident's plan of care was revised when their care needs changed.

A review of the current care plan identified that a resident required a level of assistance of staff for eating.
Observations of the resident noted that they were able to eat with a different level of assistance.
The plan of care was not revised with changes in the resident's care needs related to eating assistance.

Sources: Observations of the resident, review of the resident's care plan and interviews with staff. [s. 6. (10) (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 written plan of care set out the planned care for the resident; to ensure that the plan of care provides clear directions to staff and others who provide direct care to resident; to ensure that the resident and their SDM are given the opportunity to participate fully in the development and implementation of the resident's plan of care; and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plans of care were based on, at a minimum, an interdisciplinary assessment for three residents with respect to seasonal risk related to hot weather.

It was identified that the home completed Heat Risk Assessments on residents yearly, that the assessments were recorded in Point Click Care, and that based on the completed assessments residents would have a focus statement in their care plan with individualized interventions.
A review of the assessments completed for three residents did not include a Heat Risk Assessment completed in 2021.
Each of the three residents were last assessed for their seasonal risk of hot weather in 2020.
The current plans for the three residents did not include a current focus statement related to any potential risk related to hot weather.
The residents plans of care were not based on an assessment related to seasonal risk related to hot weather.

Sources: Review of assessments and plans of care for residents and interviews with staff. [s. 26. (3) 11.]

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 plan of care is based on, at a minimum, an interdisciplinary assessment with respect to seasonal risk related to hot weather, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to following their COVID-19 Alert System algorithm.

The home had a COVID-19 Alert System algorithm to provide direction to staff in the event that a resident presented with an acute change from their baseline for typical or atypical signs or symptoms of COVID-19.
This algorithm identified, in part, that if a resident presented with a change from their baseline that staff would isolate the resident immediately in droplet/contact precautions and if an order was received that the resident would have a nasopharyngeal swab completed.

According to the record an atypical symptom of COVID-19 was not consistent with a resident's baseline.
The resident presented with an atypical symptom of COVID-19, which continued for two days prior to staff placing the resident on droplet/contact precautions.
The following day, a nasopharyngeal swab was completed for testing of COVID-19.
The resident was negative for COVID-19.
The staff did not participate in the implementation of the IPAC program when they failed to put the resident in droplet/contact precautions when they first presented with symptoms which were not consistent with their baseline.

Sources: Progress notes for a resident and COVID-19 Alert System algorithm and interviews with staff. [s. 229. (4)]

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 all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #4: 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 :

1. The licensee failed to ensure that procedures included in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to develop an interdisciplinary medication management system and in accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that policies and protocols were developed for the accurate dispensing of all drugs used in the home.

The MediSystem procedure for telephone orders noted in part that verbal or telephone orders must be read back to the prescriber and dated and signed with both the nurse's and the prescriber's name.

In 2020, a resident was readmitted to the home from an extended hospitalization.
A review of the Re-Admission Order Form identified that medication orders were received, the date they returned to the home.
The Re-Admission Order Form did not include who accepted the orders.
The record did not include the nurse or the prescriber's name as required.

Sources: Re-Admission Order Form and progress notes for a resident and interviews with staff.

Please note this finding is additional evidence of non-compliance for CO #001 from inspection 2021_556168_0002 for Ontario Regulation (O. Reg.) 79/10, s 8. (1) related to policies, etc. to be followed, with a CDD of May 12, 2021. [s. 8. (1) (b)]

2. The licensee failed to ensure that their procedure related to dealing with complaints

was complied with.

In accordance with LTCHA, 2007 s. 21, the licensee was required to ensure that, the long term care home had written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints.

Specifically, staff did not comply with the licensee's Complaints Policy which included a procedure that required all verbal complaints, regarding the operation of the home, be responded to immediately by the individual it was addressed to and that the complaint should be recorded on the Client Service Response Form.

A discussion with an individual identified that they had previously expressed concerns to the home, which had not been addressed.
i. In 2020, a progress note identified that the individual expressed concerns regarding a resident.
A few days later the record noted that a staff member spoke with the individual regarding their concerns related to a specific care need; however, included the request of the individual for a care conference.
The home was not able to produce a record of a care conference following the identification of the concerns nor was a Client Service Response Form created.
ii. In early 2021, a progress note identified that the individual voiced concerns regarding a resident and their request that the concerns be extended to the management team.
The staff member who received the complaint documented that they sent an email to members of the management team to notify them of the concerns; however, reported that they did not initiate a Client Service Response Form.
The record noted that the physician reviewed the health records and followed up with the individual a few days later.
The record included that a member of the care team assessed the resident; however, the individual was not contacted as there was no change in the resident's plan of care.
There was no documentation to support additional actions taken regarding the concerns by members of the management team and the home was not able to provide a completed Client Service Response Form regarding the concerns.
iii. Later in the first quarter of 2021, a progress notes identified that the individual voiced concerns regarding a resident.
The staff member responded to the concerns by submitting referrals and sent an email to other members of the care team; however, did not complete a Client Service Response Form.
A few days later, the resident was assessed, changes were made changes to their

medications, and a discussion was held with the individual.
There was no documentation to support additional actions taken regarding the concerns and the home was not able to produce a Client Service Response Form for the concerns.

Sources: Review of the progress notes, assessments and Prescriber's Digiorders for a resident, review of the Complaint records, Complaints Policy, and interviews with staff.

Please note the following was further evidence to support an order issued on April 6, 2021, during inspection 2021_556168_0002 for O. Reg. 79/10, s.8 (1) related to policies, etc. to be followed, to be complied by May 12, 2021. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the temperatures required to be measured, including in two resident bedrooms in different parts of the home and in one resident common area on each of the three floors of the home were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

It was identified that maintenance staff checked and recorded the temperatures of three resident rooms a day, usually at 0800 hours.
It was identified that nursing staff were directed to check and record the temperature in a common area on each floor three times a day.
A review of the Temperature and Humidity Recording Sheet for a specific floor, for sixteen days, identified that temperatures were not recorded three times a day on 12 occasions during the identified time period.
The temperatures were not measured and documented as required.

Sources: A review of a Temperature and Humidity Recording Sheet, an excel spread sheet maintained by maintenance staff and interviews with staff. [s. 21. (3)]

WN #6: 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. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record of complaints received was reviewed and analyzed for trends at least quarterly.

A review of the progress notes identified that an individual voiced concerns to staff members at the home on three dates in 2021.
According to the APANS Health Services Dispute Resolution Tracking Tool 2021, there was only one complaint received from the individual during the first quarter of 2021.
The Quarterly Review did not include a review or an analysis of two of the complaints expressed by the individual during the first quarter of 2021.
Not all complaints received were included in the review and analyzed for trends for the first quarter of 2021 as required for determining improvements.

Sources: A review of 2021 Client Service Response Forms, 2021 Complaint Quarterly Review, APANS Health Services Dispute Resolution Tracking Tool and interview with staff. [s. 101. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

In January 2021, a resident had a physician's order for a medication to be administered for five days.
The January 2021, eMAR identified that there was a delay in the start of the medication from the time that it was ordered and that it was administered for only four days in total as the medication was not available.
The record identified that the drug was not administered as prescribed when it was not initiated when it was initially prescribed and was not administered for the full dose, of five days.

Sources: Prescriber's Digiorder, eMAR and progress notes for the resident and a staff interview.

Please note the following was further evidence to support an order issued on April 6, 2021, during inspection 2021_556168_0002 for O. Reg. 79/10, s.131 (2) related to the administration of drugs, to be complied by April 9, 2021. [s. 131. (2)]

Issued on this 16th day of June, 2021

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

Original report signed by the inspector.