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
Mar 28, 2022	2022_943988_0006	015957-21, 016136-21, 019607-21, 019966-21	Critical Incident System

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

PARMINDER GHUMAN (706988), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 22, 23, 24, 25, 28, March 1, 2, 3, 4, 7, 8, 9, 10 & 15, 2022

The following intake was completed during this Critical Incident System (CIS) inspection
Log #015957-21 (CIS# 2741-000022-21) related to fall with injury.
Log #016136-21 (CIS# 2741-000023-21) related to unexpected death of resident.
Log #019607-21 (CIS# 2741-000027-21) related to sexual assault.
Log #019966-21 (CIS# 2741-000029-21) related to missing resident sustained a fall.

The Complaint inspection # 2022_943988_0007 was completed concurrently with this CIS inspection:

PLEASE NOTE: A Voluntary Plan of Correction related to Long-Term Care Homes Act (LTCHA) chapter (c.) 8, section (s.) 6 (7) was identified in this inspection and has been issued in Inspection Report 2022_943988_0007 which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Executive Director (AED), Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs) and residents.

During the course of the inspection, the inspectors toured the home, observed residents and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services

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

4 WN(s)
4 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 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 a policy included in the required nutrition care and hydration programs was complied with.
In accordance with O. Reg. 79/10, s. 68 (2) the licensee was required to develop and implement policies and procedures related to nutrition care and dietary services and hydration.

The home's policy Oral Nutrition Supplements identified that the registered staff would be responsible to assess each resident in need of supplementation and write an order to implement supplements.

There was no order for a nutritional supplement for the resident.
Progress notes written by registered staff identified that the resident did not eat breakfast; however, took two cups of Resource, a nutritional supplement.
Registered staff confirmed that they administered the resident the nutritional supplement; however, were unable to locate an order for the supplement.

Failure to comply with the policy resulted in the resident's administration of a supplement which they were not assessed for and was not prescribed for them.

Sources: Review of Oral Nutrition Supplements, section D.1, and dated September 2017; review of the plan of care, progress notes, nutritional assessments and prescribed orders for resident ; and interviews with registered staff and other staff. [s. 8. (1) (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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to resident under the nursing services program, as required in LTCHA s. 8 (1) including assessments with a change in health condition were documented.

Resident presented with a change in condition.
Interview with registered staff identified that they assessed the resident for the status change.
There was no documentation in the clinical record by the registered staff related to the assessment for this date.

Failure to document assessment findings had the potential for a lack of communication and awareness of the change in the resident's status between members of the care team.

Sources: Progress notes, assessments and vital signs records of resident and interviews with registered staff and other staff. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, was readily available at the home to meet the nursing and personal care needs of residents.

Resident presented with a sudden change in status and there was an immediate need of the equipment.
Equipment was not available on the floor at the time of the immediate need, according to the progress notes, and as a result the resident was transported to another floor where equipment was available.
Interview with registered staff, who worked on this date, confirmed that equipment was not available on the floor when needed and the expectation is that equipment was readily available in the clean supply room on each floor.

Failure to ensure that equipment was readily available to meet the needs of the resident resulted in a delay in the administration of the required treatment.

Sources: A review of progress notes of resident's electronic health record, a review of staff statements and interview with registered staff and other staff. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed of an unexpected or sudden death of resident , who passed away after sustaining an injury from a fall.

Resident passed away unexpectedly after returning from the hospital.

Resident's death was sudden and unexpected. This was confirmed by two registered staff. The interview with DOC, confirmed after review of clinical records that resident was not palliative and it was unexpected death and the home has failed to report the unexpected death.

Sources: Resident's clinical records and Interviews with registered staff and DOC. [s. 107. (1)]

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 Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection, to be implemented voluntarily.

Issued on this 30th day of March, 2022

[redacted]

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

Original report signed by the inspector.