Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: December 1, 2023

Inspection Number: 2023-1235-0005

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Grace Villa Limited

Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

Lead Inspector	**Inspector Digital Signature**
Meghan Redfearn (000765)	Meghan Redfearn Digitally signed by Meghan Redfearn Date: 2023.12.04 15:02:13 -05'00'

Additional Inspector(s)
Yuliya Fedotova (632)
Stephanie Smith (740738)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8-10, November 14-16, and November 20, 2023

The inspection occurred offsite on the following date: November 21, 2023

The following intake(s) were inspected during the inspection:

- Intake #00022502/Critical Incident (CI) #2741-000008-23 - related to the prevention of abuse and neglect.
- Intake #00086985/CI #2741-000018-23 - related to falls prevention and management.

- Intake #00088312/CI #2741-000020-23 - related to improper/Incompetent treatment.
- Intake #00092953/CI #2741-000029-23 - related to the prevention of abuse and neglect.
- Intake #00094511/CI #2741-000034-23 - related to the prevention of abuse and neglect.
- Intake #00096187/CI #2741-000037-23 - related to falls prevention and management.
- Intake #00098664/Follow-up to compliance order #001 from inspection 2023-1235-0004 related to O. Reg 246/22 s. 37 (1) Bathing.
- Intake #00100473 - concerns related to plan of care, falls prevention and management, and transferring techniques.

The following intake(s) were completed during the inspection:

- Intake #00090215/CI #2741-000023-23; Intake #00092272/CI #2741-000028-23; Intake #00094089/CI #2741-000033-23; Intake #00097516/CI #2741-000042-23/CI #2741-000054-23; Intake #00099518/CI #2741-000052-23 - were related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1235-0004 related to O. Reg. 246/22, s. 37 (1) inspected by Meghan Redfearn (000765)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policies to be followed

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

Policies, etc., to be followed, and records s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee failed to ensure that that the policy, protocol and procedure related to urinary tract infection management were complied with.

It was documented in the plan of care on a specified date, to start a treatment of a resident and then obtain a urine sample at a later date. It was documented in the plan of care on a specified date, the urine sample was obtained. A report indicated there were microbiological organisms identified in the urine sample.

The home's Clinical Pathway for Treating Resident with Urinary Tract Infection protocol stated to check for laboratory results in two days and document the results in the plan of care. The Signs and Symptoms of Infection Subject Policy stated that

the Registered staff would identify infection on more than a single piece of evidence and microbiological or radiological findings to confirm diagnosis should always be obtained.

The resident's plan of care did not identify any documentation about the assessment of the reports results, which was confirmed by the Associate Director of IPAC.

Sources: the residents plan of care; a lab report; Clinical Pathway for Treating Resident with Urinary Tract Infection protocol and the Signs and Symptoms of Infection Subject Policy; interview with the Associate Director of IPAC.

[632]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care 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,
(c) clear directions to staff and others who provide direct care to the resident

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
On a specified date, a resident was admitted to the home. The resident's plan of care included an electronic care plan as well as a care task list. The resident's care plan indicated they required a specific number of staff to assist with transfers.

Alternatively, the resident's care task list did not match that specific number.

On a specified date, a resident received care from an agency Personal Support Worker (PSW) to transfer. The staff performed the transfer without the appropriate number of staff and the resident sustained an injury.

A Registered Practical Nurse (RPN) stated that after the incident, they identified that each location in the resident's plan of care provided different direction for the level of care required for transfer assistance. They then updated the care task list accordingly on a later date.

Failure to ensure that the resident's plan of care set out clear directions to staff, led to improper transfer assistance and injury to the resident.

Sources: Resident's plan of care; interview with RPN.

[740738]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or might occur should immediately report the

suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A Critical Incident Report in relation to the alleged staff to resident abuse was submitted to the Ministry of Long-term Care (MLTC) on a specified date. The resident's plan of care indicated that on a specified date, the resident approached the agency staff member and reported that they had an injury and they were physically abused.

The Interim Executive Director indicated that the agency's registered staff was to report to the home and the MLTC on the same day the alleged abuse happened or ask for assistance from the Director on-call.

The long-term care home's policy directed staff to immediately report the suspicion of abuse of a resident by anyone to their immediate supervisor or, if not able to do so, to the Manager on-call. The Manager was responsible for immediately reporting this suspicion to the Director (MLTC) via After Hours reporting or completing Mandatory Incident report form online and submitting to CIATT.

Sources: resident's plan of care; CI Report; interview with the Interim ED.

[632]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 3.
24-hour admission care plan s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

3. The type and level of assistance required relating to activities of daily living.

The licensee has failed to ensure that a resident's 24-hour admission care plan identified and included the type and level of assistance required relating to activities of daily living.

Rationale and Summary
A resident was admitted to the home on a specified date. The resident's 24-hour admission care plan was developed and did not include the type and level of assistance for all activities of daily living (ADLs). The resident received care for the missing ADLs during the time that they were missing from the care plan. The missing ADLs were added to the care plan on a later date.

The Resident Assessment Instrument (RAI) Coordinator acknowledged that the ADLs were added to the resident's care plan on a later date, after they had reviewed the care plan and recognized they were not included.

Failure to ensure that the resident's care plan included the certain ADLs, put the resident at risk for not receiving the type and level of assistance they required.

Sources: a resident's care plan; interview with RAI-Coordinator.

[740738]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques s. 40. Every licensee of a long-term care

home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
On a specified date, a resident was transferred by an Agency Personal Support Worker (PSW) and sustained an injury. As per their plan of care, the resident required a specific number of staff assistance for transfers. The did not perform the transfer using the appropriate number of staff.

The resident acknowledged that the transfer assistance was provided an improper number of staff and acknowledged that they sustained an injury.

Failure to ensure that staff used safe transferring and positioning techniques when transferring a resident led to actual harm as the resident sustained an injury as a result.

Sources: Resident's care plan; interview with a resident and staff.

[740738]

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the

implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to put in place a falling leaf intervention to prevent falls and/or reduce risk of injury from a fall for high risk residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that a falling leaf falls intervention was considered and put in place in the home to indicate residents who are at a high risk for falls and must be complied with.

Specifically, the licensee did not comply with the policy "Fall Prevention & Management Program- Falls Risk Factors & Related Interventions", last reviewed on January 1, 2023, which was included in the licensee's Falls Prevention and Management Program.

Rationale and Summary
The home's Fall Prevention and Management Program- Falls Risk Factors and Related Interventions policy indicated that the falling leaf intervention should be considered for a fall prevention strategy and/or to reduce the risk of injury from a fall. Under procedures for registered staff, the policy indicated residents that are a high risk with a fall will be identified by a falling leaf in an area that is well known and visible to staff.

PSW and RPN staff acknowledged the home does not have a falling leaf symbol in resident rooms and the home does not have a falling leaf program. The ADOC acknowledged the home does not have a falling leaf program and that if a falling leaf intervention was in the policy then it should be implemented in the home.

A resident was assessed as a high risk for falls. There was no falling leaf symbol

observed in their room or on the doorway. One resident room on each floor of the home that were deemed a high risk for falls were observed and no falling leaf symbol was posted.

The Interim Executive Director (ED) acknowledged there was no evidence to support that the falling leaf intervention was considered in the home and that the falling leaf intervention was not tried in the home.

Failure to ensure that the home complied with their fall prevention and management policy, related to the falling leaf intervention, put residents at risk for not being identified by staff as a high risk for falls.

Sources: a resident's falls plan of care; Fall Prevention and Management Program-Falls Risk Factors and Related Interventions policy; observation of residents; interviews with PSW, RPN, RPN, ADOC, and the Interim Executive Director (ED).

[000765]

WRITTEN NOTIFICATION: Hiring staff, accepting volunteers

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (2) (b)
Hiring staff, accepting volunteers s. 252 (2) The police record check must be,
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

The licensee has failed to ensure that where a police record check was required before a licensee hired a staff member as set out in subsection 81 (2) of the Act, the police record check was conducted within six months before the staff member was hired by the licensee.

Rationale and Summary

An Agency Personal Support Worker (PSW) began working in the home on a specified date. The hire package for the agency PSW included a vulnerable sector check (police check) that was dated eight months prior to their start at the home. The agency PSW was involved in suspected abuse incidents and was subsequently informed not to return to the home.

Interim Executive Director (ED) acknowledged that the vulnerable sector check was out of date.

Failure to ensure that the agency PSW had a police check conducted within six months prior to their working in the home, put residents at risk for harm.

Sources: Agency PSW hire package; interview with ED.

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