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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: February 1, 2024
Inspection Number: 2023-1235-0006
Inspection Type: Critical Incident Follow up
Licensee: Grace Villa Limited
Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

Lead Inspector	**Inspector Digital Signature**
Yuliya Fedotova (632)	Yuliya Fedotova Digitally signed by Yuliya Fedotova Date: 2024.02.06 11:55:06 -05'00'

Additional Inspector(s)
Meghan Redfearn (000765)
Indiana Dixon (000767)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16, 18-19, 22-26, 29, 2024
The inspection occurred offsite on the following date(s): January 22, 2024

The following intake(s) were inspected:

- Intake: #00096833 related to prevention of abuse and neglect.
- Intake: #00098663 Compliance Order Follow-up related to transferring and positioning.
- Intake: #00098802 related to prevention of abuse and neglect.
- Intake: #00098804 related to prevention of abuse and neglect.
- Intake: #00098810 related to prevention of neglect.

- Intake: #00101111 related to falls prevention and management.
- Intake: #00102976 related to prevention of abuse and neglect.
- Intake: #00105687 related to the Infection Prevention and Control (IPAC).

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, (b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(iii) contact surfaces;

The licensee failed to ensure that the home's Housekeeping policy "Daily Resident Room Cleaning LTC" was followed, specifically, in disinfection of contact surfaces in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee of a Long-Term care home was required to have, institute or otherwise put in place a Housekeeping policy to ensure that the policy was complied with.

During an inspection, a staff member indicated that high touch areas in residents' rooms were cleaned with the Universal cleaner when the home was not in outbreak.

"Daily Resident Room Cleaning LTC" policy directed staff to wet the cloth with germicidal cleaner and wipe down high-touch surfaces.

During an inspection, the Director of Environmental Services indicated that the Neutral Disinfectant was to be used for a routine disinfection of high touch surfaces in residents' rooms.

During an inspection, the Director of Environmental Services stated that the "Daily Resident Room Cleaning LTC" policy wording in Procedure Step 2: cleaning high-touch surfaces was changed from "germicidal cleaner" to "disinfectant cleaner", which was effective immediately in the home and all Housekeeping staff was informed about this update.

During an inspection, the staff member confirmed that they were informed about wording change in the policy and they need to use disinfectant for a routine

cleaning and disinfection of high touch surfaces in residents' rooms.

Sources: "Daily Resident Room Cleaning LTC" policy; interviews with staff.
[632]

Date Remedy Implemented: January 18, 2024

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse by another resident.

Rationale and Summary
A Critical incident (CI) report was submitted to the Director reporting a resident to a resident abuse. The CI report indicated that the resident was observed performing a specified action toward another resident.

During an interview with a Personal Support Worker (PSW), they informed the inspector that they observed the action of the resident performed towards another resident, and that they consider the incident that occurred as abuse.

In an interview with a Registered Practical Nurse (RPN), they stated that another resident involved in abuse had specified condition and would have not been able to

give informed consent to allow the resident to perform the specified action.
A review of clinical records, including plan of care and progress notes, indicated a specified behaviour for the resident, who performed the specified action.

The risk level was minimal, as another resident involved in the abuse was unaware of the specified responsive behaviours of the resident due to their specified condition.

Sources: Critical Incident (CI) Report System, progress notes, including social worker findings, care plans; interviews with staff.
[000767]

WRITTEN NOTIFICATION: Reports of Investigation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

1) The licensee has failed to ensure the results of the alleged abuse, involving residents, were reported to the Director upon completion.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Director regarding an alleged incident of resident-to-resident abuse. Based on the information received, the home conducted an internal investigation but did not report the results to the Director.

A review of the CIS report revealed that the home did not inform the Director of the

results of their investigation. There were no updates to the CIS report after the initial submission.

The Interim Executive Director (IED) confirmed that the results of the investigation were not reported to the Director, and that the home should have reported the results.

Failing to report the outcome of the investigation for allegations of abuse incidents to the Director may result in a risk of harm to residents.

Sources: CIS report; interview with staff.
[000767]

2) The licensee has failed to ensure that the results of an investigation into alleged neglect of a resident were reported to the Director.

Rationale and Summary
A staff member reported that they heard when a PSW specifically responded to the resident, when the resident asked specific question. CIS report initiated on the same day when the incident occurred indicated an investigation was initiated for the incident and was ongoing.

The home's Abuse or Suspected Abuse/Neglect of a Resident policy stated, when an investigation was completed, to ensure the CIS report was completed with the updated information and the update to the Director should be completed within ten days.

The Director of Clinical Services (DOCS) confirmed the investigation concluded on the next day after the incident occurred in October 2023. The Ministry of Long-Term

Care (MLTC) Ontario Long-Term Care (LTC) Homes Portal: CI Search website was reviewed and the last amended report uploaded, which was completed on the next day after the incident occurred in October 2023 and it did not include the results of the investigation.

The DOCS stated that it was management's responsibility to update the CI reports. They also stated that if the CIs were not updated on the Long-Term Care Portal then they were likely not updated. The Interim Executive Director stated if the CI amendments were not on the MLTC Ontario LTC Homes Portal, they were likely not amended and that step might have been missed. They also confirmed that CIS report did not include amendments in the investigation notes.

Failing to report the results of an investigation related to abuse and neglect to the Director might have resulted in risk to the resident.

Sources: CIS report; Abuse or Suspected Abuse/Neglect of a Resident policy, the MLTC Ontario LTC Homes Portal: CI Search website; interview with staff.
[000765]

3) The licensee has failed to ensure that the results of an investigation into alleged neglect of a resident were reported to the Director.

Rationale and Summary

A Social Worker was informed by a resident that when a PSW was asked to assist the resident they provided a specific response to the resident. CIS report indicated an investigation was initiated for the incident and was ongoing.

The home's Abuse or Suspected Abuse/Neglect of a Resident policy stated when

an investigation was completed to ensure the CIS report was completed with the updated information and the update to the Director should be completed within ten days.

The DOCS confirmed the investigation was concluded on a specified date. The MLTC Ontario LTC Homes Portal: CI Search website was reviewed and there was no evidence of an amended report.

The DOCS stated that it was management's responsibility to update the CI reports. They also stated that if the CIs were not updated on the Long-Term Care Portal, they were likely not updated. The Interim Executive Director stated if the CI amendments are not on the MLTC Ontario LTC Homes Portal then they were likely not amended and that step might have been missed. They also confirmed that CIS report in the investigation notes did not include amendments.

Failing to report the results of an investigation related to abuse and neglect to the Director might have resulted in risk to the resident.

Sources: ClS report, Abuse or Suspected Abuse/Neglect of a Resident policy, the MLTC Ontario LTC Homes Portal: Cl Search website; interviews with staff.
[000765]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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 has failed to ensure that the Social Worker immediately reported an incident of alleged resident neglect to management of the home and the Director when they were made aware.

Rationale and Summary
On a specified day in 2023, a resident reported an incident to a Social Worker, where they were neglected by a staff member.

The next day, the Social Worker reported the incident in writing stating the resident requested specified assistance from a PSW. The resident stated the PSW provided a specific response to them.

An e-mail from the Interim Executive Director dated a day following the incident stated that the resident reported abuse to the Social Worker a day prior and that they reported it in writing to them the next day in 2023. It also acknowledged the importance of reporting abuse immediately.

The home's Abuse or Suspected Abuse/Neglect of a Resident policy stated an employee shall immediately report the suspicion of abuse or neglect to their immediate supervisor and if not able to do so, the manager on-call. The manager was responsible for immediate reporting the suspicion to the Director.

The Social Worker acknowledged they did not report the incident on the same day and that they reported it to management on the following day. They also acknowledged that they had to report any incident of abuse and neglect to the management right away.

Not reporting the incident immediately put the resident at risk of not having their concern immediately investigated.

Sources: Letter from social worker #116; e-mail from Interim Executive Director, Abuse or Suspected Abuse/Neglect of a Resident policy; interviews with staff. **[000765]**

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure that the standard issued by the Director, with respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg 246/22, s. 102 (2) (b), the licensee shall implement any standard or protocol issued by the Director with respect to the IPAC.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, revised September 2023, s. 9.1 (d) states the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program, specifically proper use of PPE, including appropriate selection, application, removal, and disposal.

During an inspection, a PSW was observed entering a resident's room having a specified signage on the door, without donning personal protective equipment (PPE). The PSW touched the resident's environment in the resident's room.

The homes Infection Control Precautions Appendix I: Guidelines for specified Precautions policy stated that gloves and gowns were to be used if direct contact with the resident was required or if direct contact with frequently touched environmental surfaces was anticipated. An e-mail was sent out to all staff on a day in 2024, by the IPAC Lead reminding to always don PPE before entering a room in isolation no matter what the task was and to wear PPE anytime they passed the door threshold.

The PSW stated they only wear gloves and a gown in the room when they provided care to a resident. The IPAC Lead stated that was incorrect and staff were required to put on PPE for a resident on additional precautions at the door no matter the task. They also stated when you enter the room, the resident could request assistance or there could be an emergency and staff should be prepared prior to entering the room.

There was an increased risk of transmitting infection when the PSW did not wear PPE when entered the resident's room and making direct contact with the resident and their environment.

Sources: Observations; Infection Control Precautions Appendix I: Guidelines and Policy, e-mail sent by the IPAC Lead; interviews with staff.
[000765]

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
The licensee shall ensure that the resident and the resident's substitute decision-

maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that residents and their substitute decision makers (SDMs), were notified of the results of the investigation immediately upon completion of the investigation for the incident of alleged abuse involving both residents.

Rationale and Summary
The home had received a report of an alleged incident of resident-to-resident abuse and notified the residents' SDMs within 12 hours upon becoming aware of the incident, but did not notify them of the results of the investigation.

In a review of the residents' clinical records, including care plan and progress notes, there were no indications that the results of the investigation were reported to the residents or their SDMs. There were no records available in PointClickCare (PCC) to indicate that the residents' SDMs were informed.

In an interview with one of the resident's SDM, they stated that they had no knowledge of the outcome of the investigation, as the home did not share this information with them.

During an interview with the DOCS, they were unable to provide information to support that the residents or their SDMs were aware of the outcome of the investigation.

Failing to report the results of an investigation for allegations of abuse incidents may lead to further allegations not being reported and mistrust of residents and families.

Sources: Clinical records, including progress notes and care plan; interviews with staff and the resident's SDM.
[000767]