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: July 23, 2024
Inspection Number: 2024-1235-0002
Inspection Type: Complaint Critical Incident
Licensee: Grace Villa Limited
Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

Lead Inspector	**Inspector Digital Signature**
Indiana Dixon (000767)	Indiana A Dixon Digitally signed by Indiana A Dixon Date: 2024.07.24 07:46:11 -04'00'

Additional Inspector (s)
Barbara Grohmann (720920)

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): June 20, 21, 24, 25, 26, 27, 2024

The following intake (s) were inspected:

- Intake: #00111720 – [Critical Incident (CI): 2741-000010-24] – related to Prevention of Abuse and Neglect.
- Intake: #00114281 – Complaint with concerns regarding Resident Care and Support Services.
- Intake: #00115485 – Complaint with concerns related to Staffing, Training, and Care Standards.

- Intake: #00116070 – Complaint with concerns regarding Resident Care and Support Services.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 6.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

6. Every resident has the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

The licensee has failed to ensure that a resident had the right to communicate in confidence and consult in private with any person without interference.

Rationale and Summary

A staff entered a resident's room without knocking or waiting for a response. The

resident felt that they had no privacy to speak with someone on the phone or in person.

Failure to knock or wait for a response before entering the resident's room may have resulted in a breach of the resident's privacy.

Sources: Observations, interviews with resident and staff.
[720920].

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident received proper care consistent with their care needs.

Rationale and Summary
A resident required care but did not receive the needed care until several hours after.

Failure to provide for the resident's care needs put the resident at risk and loss of dignity.

Sources: A resident's progress notes, Residents' Bill of Rights, interview with staff.

[000767].

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was updated when the care set out in the plan was no longer necessary.

Rationale and Summary
A resident received an intervention for a specific behaviour. When the resident was no longer in need of this support, their plan of care was not updated to reflect that the technique was not required. This was also acknowledged by a member of the staffing team.

Sources: The resident's plan of care, and interview with staff.
[000767].

WRITTEN NOTIFICATION: Reports of investigation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
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).

The licensee has failed to ensure that the results of the investigation were reported to the Director immediately upon completion.

Rationale and Summary
The home completed their internal investigation on a specified date, however there were no notifications to the Director regarding the results.

Sources: Critical Incident Report, investigation notes, and interview with staff. **[000767].**

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #005 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 has failed to report an alleged incident immediately to the Director.

Pursuant to s. 154 (3) of the FLTCA 2021, the licensee is vicariously liable to staff members failing to comply with subsection 28 (1).

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director on a specified date, regarding an alleged incident that took place two days prior. A staff indicated that

upon becoming aware of the incident, they did not immediately report the incident to the management team or the Ministry's after-hour InfoLine.

Sources: Critical Incident Report and interviews with staff.
[000767].

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 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

The licensee has failed to ensure that two residents' Substitute Decision Makers (SDMs) were notified of an alleged incident.

Rationale and Summary
The home became aware of an alleged incident against two residents, however there were no information in the residents' clinical records to support that their SDMs were informed.

Sources: Critical Incident Report, residents' progress notes, and interviews with staff.
[000767].

WRITTEN NOTIFICATION: Notification re incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (2)

Notification re incidents

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 two residents and their Substitute Decision Makers (SDMs) were notified of the results of the investigation for an alleged incident, immediately upon completion.

Rationale and Summary

The home completed their internal investigation for an alleged incident on a specified date, however they did not inform the residents or their SDMs of the results.

Sources: Clinical records, including progress notes, and interview with staff. **[000767].**