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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Original Public Report

Report Issue Date: December 4, 2024
Inspection Number: 2024-1235-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Grace Villa Limited
Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 22, 25-29, 2024 and December 2-3, 2024

The following intake(s) were inspected:

- Intake #00131961 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain 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: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
During an initial tour of the home on November 22, 2024, the home's policy to promote zero tolerance of abuse and neglect of residents was not observed to be posted in the home.

The Executive Director (ED) acknowledged that the policy was not posted.

Later observations on the same day indicated that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in a hallway on the main floor.

Sources: Observations in the home, interview with the ED.

Date Remedy Implemented: November 22, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee has failed to ensure that the explanation of whistle-blowing protection was posted in the home.

Rationale and Summary
During an initial tour of the home on November 22, 2024, the explanation of whistle-blowing protection was not observed to be posted in the home.

The ED acknowledged that the explanation of whistle-blowing protection was not posted.

Later observations on the same day indicated that the explanation of whistle-blowing protection was posted in a hallway on the main floor.

Sources: Observations in the home, interview with the ED.

Date Remedy Implemented: November 22, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-

term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, during an initial tour of the home on November 22, 2024, the home's current version of their visitor policy was not observed to be posted.

The ED acknowledged that the current visitor policy was not posted.

Later observations on the same day indicated that the home's visitor policy was posted in a hallway on the main floor.

Sources: Observations in the home, interview with the ED.

Date Remedy Implemented: November 22, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #004 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; and

The licensee has failed to ensure clear direction was set out in a resident's plan of care.

Rationale and Summary
A resident's plan of care was reviewed and indicated that they required two types of assistance levels for a specified activity of daily living (ADL).

The resident's Minimum Data Set (MDS) indicated they required one type of assistance level for that ADL.

Two staff both indicated the resident required one type of assistance level for that ADL.

Failing to provide clear direction in a resident's plan of care put the resident at risk of not receiving the correct level of assistance for safe care.

Sources: A resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to comply with a resident's plan of care.

Rationale and Summary
A resident's plan of care indicated they disliked a certain type of drink and were to be provided specific nutritional interventions at meals.

Lunch was observed in the dining room. The resident was provided a drink they disliked as per their plan of care. They refused their meal and were not provided the specified nutritional intervention.

The home's registered dietitian (RD) indicated that staff were to follow the resident's plan of care, which included not providing items they disliked, and providing the specified nutritional interventions.

Failing to comply with the resident's plan of care may have impacted their nutritional care and quality of life.

Sources: Observation, interview with the RD, a resident's clinical records.

WRITTEN NOTIFICATION: Duty of Licensee to Consult Councils

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 73
Duty of licensee to consult Councils
s. 73. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months.

The licensee has failed to ensure that they consulted with the Residents' Council at least every three months.

Rationale and Summary
Residents' Council meeting minutes were reviewed for 11 months and indicated

that the ED's consultation with the council was noted as "not completed" at each meeting.

The Director of Program and Support Services (DOPSS) acknowledged that the ED did not consult with the Residents' Council at least every three months.

Failure to ensure that the licensee consulted with the Residents' Council had risk for important issues from residents to be missed.

Sources: Residents' Council meeting minutes, interview with the DOPSS, interview with the a resident.

WRITTEN NOTIFICATION: Retraining

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that a staff member was provided annual retraining in infection prevention and control (IPAC) as required under subsection 260 (1) of the regulations.

Rationale and summary
Training records were reviewed for a staff member. IPAC training was not completed for the year 2023.

The home's Associate Director of IPAC acknowledged the training was not completed.

Failing to complete annual IPAC training may impact IPAC practices that keep residents safe.

Sources: Training records 2023 for a staff member, interview with the Associate Director of IPAC.

WRITTEN NOTIFICATION: Privacy Curtains

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 16
Privacy curtains
s. 16. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The licensee has failed to ensure a resident had sufficient privacy curtains in their room to provide privacy.

Rationale and summary
During an interview with a resident, they indicated that two days prior, staff had removed one of their privacy curtains. The privacy curtain had not been replaced.

The resident shared a room with another resident. There was a small privacy curtain separating the two beds but the curtain did not provided sufficient coverage to surround the bed; the curtain only covered a small section of their bed space.

The resident had concerns that if staff were providing care and someone entered the room, there would be no privacy.

Failing to provide sufficient privacy curtains impacted a resident's quality of life.

Sources: Observations, interview with a resident.

WRITTEN NOTIFICATION: Air Temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that air temperatures in the home were maintained at a minimum of 22 degrees Celsius.

Rationale and Summary
Air temperature records were reviewed for a month. The air temperatures in the home were recorded as being less than 22 degrees Celsius on 24 out of 30 days in the first floor lobby, 18 out of 30 days in third floor lobby, and three out of 30 days in a resident room.

During the inspection, residents in a dining area were observed telling staff members that they were cold in the dining room when the air temperature was recorded as being less than 22 degrees Celsius.

A resident on the first floor informed inspector #740739 that air temperatures in the first floor lobby area fluctuate and this impacts their comfort.

Failing to maintain the temperature of the home at a minimum of 22 degrees Celsius impacted the comfort and quality of life of residents in the home.

Sources: Observations, interviews with a resident, interview with Director of

Environmental Services (DES), air temperature records for November 2024.

WRITTEN NOTIFICATION: General Requirements

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the pain management program evaluation included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
A review of the pain management program evaluation for 2023 did not indicate the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Director of Clinical Services (DOCS) acknowledged that the evaluation was not completed as per the legislative requirements.

Sources: Pain management program evaluation for 2023, interview with the DOCS.

WRITTEN NOTIFICATION: Nutritional Care and Hydration

Programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to ensure interventions that were put in place to manage a resident's nutritional risk were implemented.

Rationale and summary
A resident's clinical records indicated they required a specified fluid consistency.

The resident was observed in the dining room at lunch. A staff member served the resident their soup. Soup was observed to be a different consistency than required. The staff member served the resident and confirmed they served them a different consistency soup.

The RD was interviewed and indicated that the resident required a specified fluid consistency and this included soup.

Failing to provide the resident the correct fluid consistency may have increased their risk of aspiration.

Sources: Observations, interview with the RD and a staff member, a resident's clinical records.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure residents were provided or supported with hand hygiene prior to meals being served.

The IPAC Standard for Long-Term Care Homes, revised September 2023, section 10.2 (c), indicated the hand hygiene program for residents shall include: c) Assistance to residents to perform hand hygiene before meals and snacks;

Rationale and Summary
Lunch service was observed on a home area. Residents were transported to the dining room and staff started serving beverages and soup. Residents were not supported with hand hygiene prior to food or beverages being served.

Inspector interviewed a staff member and they indicated that hand hygiene for residents was not performed that day.

Failing to perform resident hand hygiene before serving food and drinks may increase the risk of transmission of microorganisms.

Sources: Observation, interview with a staff member. **WRITTEN NOTIFICATION: Continuous Quality Improvement Committee**

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home’s Residents’ Council.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included a member of the home's Residents' Council.

Rationale and Summary
The home's CQI and professional advisory committee (PAC) member lists were reviewed. There was no member of the home's Residents' Council listed.

The ED acknowledged that the home did not have a member of the Residents' Council as part of their quality committee.

Sources: CQI member list, PAC meeting minutes, interview with the ED.

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