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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Public Report

Report Issue Date: April 23, 2025
Inspection Number: 2025-1235-0004
Inspection Type: Complaint Critical Incident Follow up
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): April 14, 15, 17, 22, 23, 2025

The following intake (s) were inspected:

- Intake: #00138432 - [Critical Incident (CI): 2741-000004-25] related to Falls Prevention and Management.
- Intake: #00140436 - Follow-up #: 1 to CO #001 from Inspection #2025-1235-0002 - FLTCA, 2021 - s. 24 (1) Duty to protect, CDD: April 4, 2025.
- Intake: #00144074 - [Complaint: 0138665-HA] related to Safe and Secure Home.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1235-0002 related to FLTCA, 2021, s. 24 (1)

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

Safe and Secure Home
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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 ensure that the falls prevention strategies set out in a resident's written plan of care was carried out as specified in their plan.

A resident did not have their falls intervention strategies in place while they were in bed.

Sources: A resident's plan of care and observation.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care outlined in a resident's written plan of care was documented. The resident's plan of care stated that staff were to conduct safety checks hourly to ensure their safety, due to their falls risk.

Safety checks were not conducted as required according to their clinical records and staff interview.

Sources: A resident's clinical records, including care plan, Documentation Survey Report, Point of Care records, and staff interview.

WRITTEN NOTIFICATION: Air temperature

NC #003 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 the home was maintained at a minimum temperature of 22 degrees Celsius.

Documentation from the home's temperature sensor data showed that the minimum requirement was not met on several days within a given month in 2025. This was also acknowledged by staff of the home.

Sources: The home's Temperature Monitoring policy, temperature sensor data and staff interview.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a head-to-toe assessment was completed for a resident when they had an unwitnessed fall.

The home's Falls Prevention and Management policy directed registered staff to proceed with head toe assessment after a resident had a fall, however a head-to-toe assessment was not completed until three days later.

Sources: The home's Fall Prevention and Management Program policy and a resident's progress notes.