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: August 21, 2025
Inspection Number: 2025-1235-0007
Inspection Type: Complaint Critical Incident
Licensee: Grace Villa Limited
Long Term Care Home and City: Grace Villa Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred on-site on the following dates: August 13, 15, 18-21, 2025 and off-site on the following date: August 14, 2025.

The following critical incident (CI) intakes were inspected:
- Intake 00151723/ CI 2741-000022-25 was related to prevention of abuse and neglect
- Intake 00152209/ CI 2741-000023-25 was related to fall prevention and management

The following complaint intake was inspected:
- Intake 00153694 was related to medication management

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

Medication Management
Prevention of Abuse and Neglect
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. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure the fall prevention and management program was implemented for a resident. In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidence of falls and injury risk, and that it was complied with. Specifically, staff did not comply with the program where they were required to ensure preventative interventions were included in the resident's care plan. During the inspection, the specified intervention was added to the resident's care plan.

Sources: Resident observation, resident's clinical record, fall prevention and management program, interview with nursing management.

Date Remedy Implemented: August 20, 2025

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)
Duty to protect
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 failed to protect a resident from physical and verbal abuse by a co-resident.

Section 2 of O. Reg. 246/22 defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

A) On a specified date, a resident physically abused a co-resident, resulting in the co-resident sustaining a physical injury.

Section 2 of O. Reg. 246/22 defines "verbal abuse" as any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences.

B) During the same incident noted above, the resident was verbally abusive toward the co-resident, resulting in the co-resident feeling fearful.

Sources: Resident clinical records, critical incident report, interview with nursing

management.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure the fall prevention and management program was implemented for a resident. In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidence of falls and injury risk, and that it was complied with.

Specifically, staff did not comply with the program where it required staff to implement the fall interventions for the resident. On a specified date, the resident's fall intervention was not implemented in accordance with their plan of care.

Sources: Resident observation, resident's clinical record, fall prevention and management program, interview with direct care staff.