Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2013	2013_105130_0031	H-002246-12	Complaint

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE, LONDON, ON, N6B-2C8

Long-Term Care Home/Foyer de soins de longue durée

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

GILLIAN TRACEY (130), CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 23, 24, October 3, 4, 25, 28, 29 and November 7, 2013

This inspection was conducted in part by Inspector Cynthia DiTomasso.

Please Note: This inspection was conducted simultaneously with the following inspections:H-002256-12, H-000228-13, H-000671-13 and H-000028-13.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Registered Staff, Personal Support Workers, dietary staff, residents and families related to H-002246-12.

During the course of the inspection, the inspector(s) Interviewed staff, residents and families, reviewed clinical records, relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

a) The plan of care for resident #001 indicated: resident to have call bell within reach while on toilet and encourage use, however the plan also indicated required one person constant supervision and physical assist for safety, while toileting; not always compliant with calling for assistance with transfers; often will be found transferring self; staff to continue to encourage to use the call bell for assistance and to monitor frequently to ensure resident is not attempting to mobilize without assistance; provide guidance and physical assistance for all transfers; allow resident to attempt all movements by self before offering assistance; "hi-low" bed in lowest comfortable position for resident, not at its lowest position as resident requires the bed at a slightly higher position to assist to stand up out of bed; however, the plan also indicated, ensure bed is in lowest position while resident in bed. The plan stated resident

preferred left half rails up, but it also stated resident would be at risk for injury due to behaviour of climbing a rail should it be up. Staff interviewed verified the plan did not provide clear directions.

b) The plan of care for resident #003 indicated the resident required one person assist for constant supervision and total care during toileting; required specific type of incontinent product, however the plan also indicated the resident required a different type of product. Two staff interviewed stated the resident was toileted after breakfast and after lunch as the resident will not ask to be toileted. Two different front line staff interviewed stated the resident was toileted before and after meals, but only if the resident was cooperative, otherwise the resident would be changed in bed. Staff interviewed confirmed the plan did not direct staff when to toilet the resident or change incontinent products. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was based on an assessment of the resident and the needs of the resident.

a) The quarterly minimum data set (MDS) assessment and the resident assessment protocol (RAP) completed for resident #003 in 2013, indicated the resident was incontinent of bowel and bladder; required an incontinent product and required assistance with toileting. The plan of care developed for continence indicated there was a potential to restore function related to urinary incontinence. Interventions included: teach resident importance of emptying bladder. The focus statement for toileting indicated a potential to restore function to maximum self sufficiency for the physical process of toileting, with the goal to maintain the resident's ability to toilet self safely and appropriately. Registered staff and personal support workers confirmed the resident was completely incontinent and that there was no potential to restore function, the resident required at least one staff assistance with all aspects of toileting and there was no potential to restore independent toileting. [s. 6. (2)]

3. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

a) The plan of care for resident #003 indicated the resident required a treatment to a specific area. The registered staff documented the location of the affected area on the initial assessment and documented the location of the affected area incorrectly at

least eleven times until the treatment was discontinued. Registered staff confirmed this information.

4. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) According to the plan of care resident #001 preferred the left half rail up when in bed. On a specific date in 2013, the resident was observed in bed at approximately 1100 hours, with two rails up. Staff interviewed stated the resident should have two rails down as the resident will rise from the bed unassisted, however, different staff interviewed in 2013, stated the resident usually has two bed rails up, but probably only needs one up.

b) The plan of care for resident #003 indicated the resident required specific care to be completed on bath days. In 2013, registered staff completed a head to toe assessment, which indicated there were no concerns to a specific area. Shortly after, registered staff recorded that the specific area identified on the head to toe assessment required monitoring and gentle care. During the same time period in 2013, front line staff reported the resident required care to the specific area. Within days of staff reporting their concern, the Power of attorney (POA) reported to staff that the affected area had worsened and required assessment and treatment. Registered staff assessments confirmed the resident required treatment to the affected area. According to the point of care (POC) records, the resident was not consistently receiving specific care on bathing days, as specified in the plan. Registered staff and the DOC confirmed the resident was not receiving care to the affected area through the home's contracted service provider.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is based on an assessment of the resident and the needs of the resident, that the staff and others involved in the different aspects of care of the resident collaborate with each other so that their assessments are integrated and are consistent with and complement each other and that the care set out in the plan is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

a) In 2013, resident #002 activated their call bell from the bedside. The resident could not recall the time of activation but reported they had been waiting a considerable amount of time for staff to respond. The call bell was monitored from approximately 1155 hours and not responded to by staff until 1210 hours. [s. 3. (1) 4.]

Issued on this 13th day of December, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130), CYNTHIA DITOMASSO (528)
Inspection No. / No de l'inspection :	2013_105130_0031
Log No. / Registre no:	H-002246-12
Type of Inspection / Genre d' inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 18, 2013
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WENDY HALL

To GRACE VILLA LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how they will ensure that care set out in the plans are provided to residents, including residents #001 and #003. The plan shall be submitted to Gillian Tracey at Gillian.Tracey@ontario.ca by November 30, 2013.

Grounds / Motifs :

1. 1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) According to the plan of care resident #001 preferred the left half rail up when in bed. On a specific date in 2013, the resident was observed in bed at approximately 1100 hours, with two rails up. Staff interviewed stated the resident should have two rails down as the resident will rise from the bed unassisted, however, different staff interviewed in 2013, stated the resident usually has two bed rails up, but probably only needs one up.

b) The plan of care for resident #003 indicated the resident was to receive specific care on bath days. In 2013, registered staff completed a head to toe assessment, which indicated there were no concerns to a specific area. Shortly after, registered staff recorded that the specific area identified on the head to toe assessment required monitoring and gentle care. During the same time period in 2013, front line staff reported the resident required care to the specific area. Within days of staff reporting their concern, the Power of attorney (POA) reported to staff that the affected area had worsened and required assessment and treatment. Registered staff assessments confirmed the resident required treatment to the affected area. According to the point of care (POC) records, the resident was not consistently receiving specific care on bathing days, as specified in the plan. Registered staff and the DOC confirmed the resident was not receiving care to the affected area through the home's contracted service provider.

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu' il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Direction de l'amélioration de la performance et de la conformité Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of November, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : GILLIAN TRACEY

Service Area Office / Bureau régional de services : Hamilton Service Area Office