Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection **September 7, 8, 9, 2010**	**Inspection No/ d'inspection** **2010_168_2741_07Sept085510**	**Type of Inspection/Genre d'inspection** **Other – Critical Incident** **H-01144**

Licensee/Titulaire
Grace Villa Limited
284 Central Avenue
London ON N6B 2C8
Fax 519-672-8729

Long-Term Care Home/Foyer de soins de longue durée
Grace Villa Nursing Home
45 Lockton Crescent
Hamilton ON L8V 4V5

Name of Inspector/Nom de l'inspecteur
Lisa Vink, #168

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Other – Critical Incident inspection.

During the course of the inspection, the inspector spoke with:
The Administrator, Assistant Director of Nursing, the charge Registered Nurse and front line staff

During the course of the inspection, the inspector:
Reviewed the lay out of the third floor resident home area, reviewed one clinical record and interviewed staff

The following Inspection Protocols were used during this inspection:
Critical Incident Response

X Findings of Non-Compliance were found during this inspection. The following action was taken:

[2] WN
[2] VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s 3(1)16

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately

Findings:
1. The specified resident was transferred to the hospital after a sudden change in his condition. Staff at the home did not notify the family/SDM of this transfer, this information was communicated, to the family, by hospital staff.

Inspector ID #:	168

Additional Required Actions:
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 for LTCHA, 2007, S.O. 2007 c.8, s 3(1) 16, to ensure that the person designated to receive information concerning any transfer or hospitalization of a resident receive that information immediately, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s 6(1)c

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:
1. The specified resident's document that staff refer to as the "Care Plan", does not give clear direction to staff providing care related to the use of bedrails in bed. Under the one Focus statement it notes that the resident is to use only one 1/2 bedrail, however, in a second Focus statement it notes that both bed rails up when in bed due to increased weakness.

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Additional Required Actions:
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 for LTCHA, 2007, S.O. 2007 c.8, s 6(1)c, to ensure that the written plan of care sets out clear direction for staff and others who provide direct care to residents, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** October 1/10
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).