Ontario

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

Rapport d'inspection prevue 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
Direction de l'amélioration de la performance et de la conformité

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119 King Street West, 11th Floor
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
28 July 2010	2010_127_2741_27Jul163325	Follow up (H-01775)

Licensee/Titulaire

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(s)

Richard Hayden – LTC Homes Inspector – Environmental Health #127

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection in respect of the following previously identified non-compliance:

Complaint Investigation #418-2010, 18 May 2010

- M1.18

Probationary Risk Review, 08 June 2010

- NHA, R.S.O. 1990 c. 7, s.20.11: previously issued as M3.23
- O. Reg. 832, s. 21(1): previously issued as O2.1 and O2.12
- B3.16

The inspection was conducted by one (1) inspector, named above, on 28 July 2010. The inspector was in the home for one (1) day. During the course of the inspection, the inspector spoke with the administrator, DOC, ADOC, Environmental Services Manager, Nutrition Manager, housekeeping staff and residents.

The following Inspection Protocols were used during this inspection:

- Accommodation Services - Housekeeping
- Accommodation Services – Maintenance
- Safe and Secure Home

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

7 WN
4 CO: CO # 1, CO # 2, CO # 3, CO # 4,

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

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

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'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue 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. 5:
Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:
28 July 2010

1. 1st Floor dining room - A hot steam table was left unattended. The unit was turned off but hot water was left in 4 of its wells and steam was still coming from these wells. The dining room is open to the general area on the 1st Floor and residents have access to the steam table.

Inspector ID #:	127

CO #1 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c. 8, s. 15.(2)(a):
Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are kept clean and sanitary.

Findings:
28 July 2010

1. Mouse droppings were observed beneath the heaters in identified resident rooms.
2. Dead mice on traps were found in identified resident rooms.
3. The carpet was heavily stained in the 1st floor and 3rd floor lounges.
4. Two heavily stained and soiled falls arrest mattresses were propped in the corner next to the window in an identified resident room.
5. A strong urine odour was detected in a shared washroom.
6. Splattered food, saliva and/or expelled food residue was observed on the walls and heater next to a bed in an identified resident room.

Inspector ID #:	127

CO #2 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c. 8, s. 15.(2)(c):
Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:
28 July 2010

1. Regular and raised toilet seats were found to be loose in identified resident rooms.
2. Toilets were found not secured to the floor allowing them to rock back and forth at the base in identified areas.
3. The water in the toilet was running continuously in an identified resident washroom. The tank was draining on its own and continually refilled after the water had drained to a certain level.
4. An unpainted block of wood (a piece of two-by-four) was attached to the wall behind the door for the purpose of a door-stop in an identified resident room.

Inspector ID #:	127

CO #3 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #4: The Licensee has failed to comply with: O. Reg. 79/10, s. 87(2)(a)(i):
As part of the organized program of housekeeping under clause 15.(1)(a) of the Act, the licensee shall ensure that procedures are developed and implemented for, cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

Findings:
28 July 2010

1. Mouse droppings were observed beneath the heaters in identified resident rooms.
2. Dead mice on traps were found in identified resident rooms.
3. The carpet was heavily stained in the 1st floor and 3rd floor lounges.
4. Two heavily stained and soiled falls arrest mattresses were propped in the corner next to the window in an identified resident room.
5. A strong urine odour was detected in a shared washroom.
6. Splattered food, saliva and/or expelled food residue was observed on the walls and heater next to a bed in an identified resident room.

Inspector ID #:	127

CO #4 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #5 The Licensee has failed to comply with: O. Reg. 79/10, s. 87(2)(a)(ii): As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.
Findings: 28 July 2010 1. The carpet was heavily stained in the 1st floor and the 3rd floor lounges.

Inspector ID #:	127

WN #6: The Licensee has failed to comply with: O. Reg. 79/10, s. 90(2)(d): The licensee shall ensure that procedures are developed and implemented to ensure that, all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.
Findings: 28 July 2010 1. Regular and raised toilet seats were found to be loose in identified resident rooms. 2. Toilets were found not secured to the floor allowing them to rock back and forth at the base in identified areas. 3. The water in the toilet was running continuously in an identified resident washroom. The tank was draining on its own and continually refilled after the water had drained to a certain level.

Inspector ID #:	127

WN #7 The Licensee has failed to comply with: O. Reg. 79/10, s. 91: The licensee shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.
Findings: 28 July 2010 1. Hairdressers left the salon without locking the door behind them. Barbicide and bottles containing disinfectant were accessible to residents when the room was left unlocked and unattended.

Inspector ID #:	127

CORRECTED NON-COMPLIANCE Non-respectés à Corrigé				
REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
M1.18, LTC Homes Program Manual now found in O. Reg. 79/10, s. 229 (4).			Complaint Investigation #418-2010, 18 May 2010	127
NHA, R.S.O. 1990 c. 7, **s.20.11** (previously issued as **M3.23**, LTC Homes Program Manual now found in *LTCHA, 2007*, c.8. s. 84 and O. Reg. 79/10, s. 229 (4))			Probationary Risk Review, 08 June 2010 **B3.16** and O. Reg. 832, s. **21(1)** (previously issued as **O2.1 and O2.12**) remain outstanding	127

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.
Title: Date:	Date of Report (if different from date(s) of inspection). 25 October 2010

Ontario

Ministry of Health
and Long-Term Care

ORDER(S) of an Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Public Copy

Inspector Name:	Richard Hayden
Inspection ID #:	2010_127_2741_27Jul163325
Type of Inspection:	Follow up (H-01775)
Date Order Made:	01 October 2010
Date Order Served:	06 October 2010
Licensee:	Grace Villa Limited
LTC Home:	Grace Villa Nursing Home
Name of Administrator:	Lynette Tyler

To Grace Villa Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Compliance Order #: 1

Pursuant to: LTCHA, 2007, S.O. 2007, c. 8, s. 5.
Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee shall installing barriers around the 1st Floor dining room steam table to restrict resident access to it.

Grounds:

- 1st Floor dining room - A hot steam table was left unattended. The unit was turned off but hot water was left in 4 of its wells and steam was still coming from these wells. The dining room is open to the general area on the 1st Floor

and residents have access to the steam table.

Inspector ID# 127
This order must be complied with by: 31 October 2010

Compliance Order #: 2

Pursuant to: LTCHA , 2007, S.O. 2007, c. 8, s. 15.(2)(a) Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are kept clean and sanitary.

The licensee shall:

1. **clean all areas where mouse droppings are found;**
2. **check for and remove mice from traps on a daily basis; and**
3. **clean the carpets in the 1st floor and 3rd floor lounges to remove heavy stains.**

Grounds:

- Mouse droppings were observed beneath the heaters in identified resident rooms.
- Dead mice on traps were found in identified resident rooms.
- The carpet was heavily stained in the 1st floor and 3rd floor lounges.
- Two heavily stained and soiled falls arrest mattresses were propped in the corner next to the window in an identified resident room.
- A strong urine odour was detected in a shared washroom.
- Splattered food, saliva and/or expelled food residue was observed on the walls and heater next to a bed in identified resident room.

Inspector ID# 127
This order must be complied with by: 31 October 2010

Compliance Order #: 3

Pursuant to: LTCHA , 2007, S.O. 2007, c. 8, s. 15.(2)(c) Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee shall:

1. **repair, secure and keep secured all toilet seats and toilets in identified resident rooms and in the 2nd North tub room; and**
2. **remove the unpainted block of wood from the wall behind the door in an identified resident rooms and install a proper door stop.**

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Grounds:

- Regular and raised toilet seats were found to be loose in identified resident rooms.

- Toilets were found not secured to the floor allowing them to rock back and forth at the base in identified areas.
- The water in the toilet was running continuously in an identified resident room. The tank was draining on its own and continually refilled after the water had drained to a certain level.
- An unpainted block of wood (a piece of two-by-four) was attached to the wall behind the door for the purpose of a door-stop in an identified resident room.

Inspector ID# 127
This order must be complied with by: 31 October 2010

Compliance Order #: 4

Pursuant to: O. Reg. 79/10, s. 87(2)(a)(i): As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces,

The licensee shall implement cleaning procedures that include resident bedroom floors and wall surfaces and ensure housekeeping staff and others responsible for cleaning the home follow these procedures.

Grounds:

- Mouse droppings were observed beneath the heaters in identified resident rooms.
- Dead mice on traps were found in identified resident rooms.
- The carpet was heavily stained in the 1st floor and 3rd floor lounges.
- Two heavily stained and soiled falls arrest mattresses were propped in the corner next to the window in an identified resident room.
- A strong urine odour was detected in a shared washroom.
- Splattered food, saliva and/or expelled food residue was observed on the walls and heater next to a bed in identified resident room.

Inspector ID# 127
This order must be complied with by: 31 October 2010

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Signature of Inspector(s): _____

Date: 25 October 2010

Time Order is Served: