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
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
August 18, 2010	2010-173-2741-16Aug150246	CIS Review Log # H00501

Licensee/Titulaire
Grace Villa Limited
284 Central Ave, London, Ontario N6B 2C8

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

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – # 173 - Compliance Inspector – Nursing

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to responsive behaviours.

During the course of the inspection, the inspector spoke with: The Administrator, Assistant Director of Care, Corporate Consultant, Registered Staff, Residents, and Personal Support Workers.

During the course of the inspection, the inspector: observed residents, reviewed the clinical records, shift reports, plan of care.

The following Inspection Protocols were used during this inspection:
Responsive Behaviors Inspection Protocol.

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

[1] WN

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 **Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s6(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. 2007, c. 8, s. 6 (1).

Findings:

1. Critical incident report submitted to Hamilton Service Area Office indicates that an identified resident was involved in an incident. Resident assessment protocol (RAP) dated May 2010, noted the resident's behaviour. This behaviour was observed in August, 2010 during inspection at the home. The home indicated that they have a plan with the psychogeriatric resource person (PRC) related to behaviors. This method has been successful in reducing the number of outbursts in the home. The information related to this meeting with the PRC and the strategies developed as a result were not found on the resident's plan of care.

2. The resident was observed by the compliance inspector to demonstrate behaviours on the home area. These behaviors and interventions to manage the behaviour were not captured on the plan of care for this resident.

3. The CIS incident investigated was detailed in progress notes dated on the day of the incident. The resident got very upset and reacted before staff could intervene. It was noted after the incident that staff approached the resident and negotiated that the resident ignore this co-resident when the co-resident is upset. The resident agreed to do this. There is no plan of care for specified behaviors currently for this resident that includes this intervention for staff to follow.

Inspector ID #:	173

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.** Revised for the purpose of publication. Name signed Aug 5/11 for
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). L Wolff
