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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: September 27, 2023	
Inspection Number: 2023-1358-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Governing Council of the Salvation Army in Canada	
Long Term Care Home and City: The Salvation Army Ottawa Grace Manor, Ottawa	
Lead Inspector Megan MacPhail (551)	**Inspector Digital Signature** Megan K MacPhail Digitally signed by Megan K MacPhail Date: 2023.10.05 12:56:02 -04'00'
Additional Inspector(s) Karen Buness (720483)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28, 29, 30, 31, 2023 and September 1, 5, 6, 7, 8, 2023.

The following intake(s) were inspected:

- Intake: #00095476 was related to a Proactive Compliance Inspection.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control

Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Menu Planning

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee has failed to ensure that the planned menu items were offered to a resident at a lunch meal.

Rationale and Summary

The planned menu items for the lunch meal included an assortment of beverages, hot and cold.

A resident received soup, an entree and dessert. The resident was not offered a beverage with their lunch meal.

The resident's care plan stated that they were to receive a supplemental beverage at lunch, and that they required a specific amount of fluids daily to meet their need.

The resident was assessed as being at nutritional risk. They were not provided a beverage, including a supplemental beverage, with lunch to assist in meeting their hydration needs and to cleanse and refresh the mouth.

Sources: Observations and a resident's health care record.

[551]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee has failed to comply with the policy to ensure that foods were being served at a temperature that was both safe and palatable to residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the nutritional care and hydration programs included the development and implementation of policies and procedures relating to nutritional care and dietary services and hydration, and they must be complied with.

Specifically, the licensee did not comply with the policy titled, Food Safety Temperature Control which was included in the licensee's Nutritional Care and Hydration Programs. The policy stated that 4) Food temperature checks must be conducted on all menu items in each resident home area (RHA) just prior to meal service.

Rationale and Summary

The Temperature Report for a RHA showed that at the lunch meal service, a temperature check was not conducted on the regular and minced salads and the minced and pureed cantaloupe prior to meal service.

The Nutritional Manager (NM) and Food Services Supervisor (FSS) stated that a temperature check was expected for each menu item prior to meal service.

By not conducting a temperature check, the food items may have been served to residents at a temperature that was not safe and palatable.

Sources: The Temperature Report, Food Safety Temperature Control policy and interviews with the NM and FSS.

[551]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.

The licensee has failed to ensure that the lunch meal included course by course service for two residents.

A) Rationale and Summary

A resident was served soup. Before the resident was assisted to eat the soup, their entree was served.

A staff sat and assisted the resident to eat the soup, then their entree. After the entree was completed, the remaining soup was served to the resident.

[551]

B) Rationale and Summary

A resident was served their entree while they were eating soup.

Dessert was served while they were eating their entree.

The health care records for the residents were reviewed, and there was no indication that the residents, or their assessed needs indicated, that they were not to receive course by course service of meals.

The NM stated that residents were to be served course by course.

Sources: Observations, residents' health care records and interview with the NM.

[551]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee has failed to ensure that a resident was provided with eating aids to eat as comfortably as possible.

Rationale and Summary

The resident was served their entree. They ate it all using their fingers, as they did not have cutlery or did not know that there was cutlery.

The resident's dessert was served in a bowl with a spoon. They used the spoon to eat dessert, then used the spoon to eat remaining food from their entree.

The resident's health care record was reviewed, and there was no indication that they were not to be provided with cutlery to eat their meal.

In the absence of available cutlery, the resident used their fingers to eat their entree. They were not provided with eating aids to eat as comfortably as possibly.

Source: Observations and a resident's health care record.

[551]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that immediate action was taken to reduce transmission and isolate a resident when they had symptoms indicating the presence of infection.

Rationale and Summary

A resident had symptoms indicating the presence of infection. Isolation under droplet-contact precautions was not implemented.

On the following day shift, additional symptoms indicating the presence of infection were noted, and the presence of infection was confirmed with a test.

The resident's room-mate became symptomatic, and the presence of infection was confirmed with a test.

The IPAC Lead stated that isolation for the resident should have been implemented with the onset of their symptoms.

Immediate action was not taken to reduce transmission through the implementation of isolation precautions when the resident had symptoms indicating the presence of infection.

Sources: Residents' health care records and interview with the IPAC Lead.

[551]