Ontario

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2014	2014_312503_0026	H-000721, 722, 723-14	Follow up

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

LAURA BROWN-HUESKEN (503), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 2, 3, and 4, 2014

During the course of the inspection, the inspector(s) spoke with Director of Care, Nutrition Manager, Registered Nursing staff, Registered Dietitian, Personal Support Workers, Cooks and Dietary Aides

The following Inspection Protocols were used during this inspection:

Dining Observation
Food Quality
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2014_214146_0009	503
O.Reg 79/10 s. 73. (2)	CO #004	2014_214146_0009	503

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 O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

The preparation of the lunch meal was observed on December 2, 2014, and not all items were prepared using methods to preserve taste, nutritive value, appearance and food quality.

A) The instructions on the dry soup mix used in preparation of the potato and leek soup indicated to add one package of dry soup mix to four liters (L) of hot water. The cook was observed to add 1.25 packages of soup mix to approximately 7.6 L of hot water. The soup was diluted resulting in reduced nutritive value and taste.
B) The recipe for the puree turkey dressing bread casserole directed staff to add specified amounts of the prepared casserole and poultry gravy mix to a food processor and blend until the desired consistency was reached. The cook did not use the prepared casserole to prepare the puree product. A mixture of bread, turkey, water, chicken soup base, gravy and prepared casserole were used in the preparation of the puree product. The resulting product did not have the ratio of ingredients outlined in the recipe and resulted in altered nutritive value and a less flavourful product.
C) The recipe for the beef pastrami sandwich on rye directed staff to spread margarine on the rye bread and add pastrami to form a sandwich. A cook and dietary aide were observed to spread mayonnaise and margarine on the rye bread resulting in altered taste and nutritive value of the sandwiches.
D) The recipe for the minced mandarin orange directs staff to add the oranges to a food processor and mince until the desired consistency is reached. The dietary aide added thickener to the oranges resulting in an altered food quality.
E) The recipe for the pureed mixed oriental vegetables directs staff to add margarine and cooked vegetables to a food processor and mince until the desired consistency is reached. The cook added thickener to the vegetables resulting in an altered food quality. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (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 failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

During the lunch meal service on an identified date, resident #012 was observed to have two personal assistive service devices, with the potential to restrain movement, applied. A review of the resident's written plan of care revealed that the resident required one device for positioning purposes, however, the second had been removed from the care plan on an identified date. Review of clinical documentation revealed that the resident was assessed to need the second device as a personal assistive service device related to positioning. Documentation further reveals that the device remains a physician's order and that staff continue to apply the device daily and monitor the resident hourly when it is applied. An interview with the Director of Care confirmed that the device remained planned care for the resident and should have been in the resident's written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident's plan of care was based on an assessment of the resident's needs.

Resident #011 had a plan of care to receive extensive assistance with meals. On an identified date, during lunch meal service resident #011 was observed receiving total

assistance with eating from a Personal Support Worker (PSW). The PSW stated the resident required total assistance for approximately a year, and could not self-perform any part of eating. Registered nursing staff confirmed the resident required total assistance with eating. A look-back report of the resident's self-performance at meals over a one month period revealed that the resident required total assistance with eating for 83 of the last 86 meals. The most recent nutrition assessment note completed by the Registered Dietitian stated the resident required extensive assistance. The resident's plan of care was not based on an assessment of the resident's current needs. [s. 6. (2)]

3. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the lunch meal service on an identified date, resident #001 was served a minced meat pastrami sandwich and regular texture greek salad. The resident indicated that he/she believed he/she had received the wrong meal as his/her meat is not usually ground up, but ate the sandwich as he/she was unable to get the attention of staff. A review of the resident's care plan and the master diet list notes located in the servery revealed that the resident's diet is regular texture. An interview with the Nutrition Manager confirmed that the resident was not served the correct texture as per the resident's plan of care. [s. 6. (7)]

4. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the lunch meal service on an identified date, resident #004 indicated his/her preference for the entrée to be the turkey dressing casserole. The chosen entrée was served to the resident with a sauce poured over top. The resident became agitated indicating he/she did not like the sauce. The meal was replaced with the second option which the resident indicated was acceptable to him/her. A review of the resident's care plan and the master diet list notes located in the servery revealed an identified dislike of the sauce. An interview with the Nutrition Manager confirmed that the resident was served the meal based on his/her preferences outlined in his/her plan of care. [s. 6. (7)]

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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

The lunch menu for December 2, 2014, included a pastrami sandwich on rye, greek salad and pickle spear. Residents #001, #004, and #005 were served the pastrami sandwich on rye and greek salad but were not served the pickle spear. An interview with the Dietary Aide confirmed that the pickle spears were not served due to forgetting they were part of the menu.

The lunch menu for December 2, 2014, included three courses; soup, entrée and dessert. Residents #002 and #003 were not provided the soup course. Interviews with staff reveal that resident #002 does not consume the soup, however this was not indicated as a preference in the resident's care plan or the master diet list notes located in the servery.

An interview with the Nutrition Manager confirmed that the identified residents were offered menu items as per the planned menu. [s. 71. (4)]

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 to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During the lunch meal service on an identified date, residents #006 and #007 were served their entrees while they were still consuming their soup. Neither resident was noted to identify this as a preference. Staff interviews revealed that resident #007 is served multiple courses to prevent the resident from wandering. Review of the resident's care plans and the master diet list notes located in the servery did not reveal planned interventions for service of multiple courses at one time. An interview with the Nutrition Manager confirmed that the residents should have received course by course meal service. [s. 73. (1) 8.]

2. The licensee has failed to ensure that safe positioning techniques were used to assist resident #012 with eating.

On a specified date, during lunch meal service, in an identified dining room, resident #012 was observed in a tilted Broda chair, at a 45 degree position, and was receiving full assistance with eating. The resident's plan of care stated their Broda chair was to be tilted for comfort and positioning at all times unless eating. The Registered Dietitian confirmed the resident was not safely positioned. [s. 73. (1) 10.]

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 to ensure that the home has a dining and snack service that includes course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs and that safe positioning techniques are used to assist residents with eating, to be implemented voluntarily.

Ontario

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

Issued on this 12th day of January, 2015

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

Original report signed by the inspector.

Ontario

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) :	LAURA BROWN-HUESKEN (503), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2014_312503_0026
Log No. / Registre no:	H-000721, 722, 723-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 19, 2014
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 :	Annette Prentall

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_214146_0009, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall:
1) Provide training for all cooks and dietary aides related to the preparation of foods and fluids in the food production system.
2) The development and implementation of a mechanism to ensure all staff who prepare foods and fluids follow standardized recipes.

Grounds / Motifs :

1. Previously issued: May 2012 as a CO, February 2013 as a CO, November 2013 as a CO, and May 2014 as a CO.

The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

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D) The recipe for the minced mandarin orange directs staff to add the oranges to a food processor and mince until the desired consistency is reached. The dietary aide added thickener to the oranges resulting in an altered food quality.
E) The recipe for the pureed mixed oriental vegetables directs staff to add margarine and cooked vegetables to a food processor and mince until the desired consistency is reached. The cook added thickener to the vegetables resulting in an altered food quality.
(503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

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 19th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Laura Brown-Huesken

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