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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 25, 2019	2019_689586_0004	032368-18, 032493-18, 004713-19, 008133-19, 008137-19	Complaint

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

JESSICA PALADINO (586), CATHIE ROBITAILLE (536)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 11, 12, 15, 16, 17 and 18, 2019.

The following Complaint Inspections were completed during this inspection:
032368-18 - Food Quality; and,
004713-19 - Medication Administration.

The following Follow-Up Inspection was completed concurrently with the Complaint Inspections:
032493-19.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Clinical Services (DCS), Director of Culinary Services (DCS), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary staff, residents and families.

During the course of the inspection, the inspectors toured the home, observed meal production and dining service, reviewed resident health records, internal compliance plans, training records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 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
O.Reg 79/10 s. 131. (2)	CO #001	2018_587129_0003	586
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_587129_0004	586
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_704682_0023	586

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

A Complaint was submitted to the Director on an identified date in 2018 in regard to the food quality in the home, by resident #001's family member. In an interview with the resident on an identified date in 2019, they confirmed this with the Long-Term Care Home (LTCH) Inspector.

A review of the resident's progress notes and a Client Services Response (CSR) Form indicated that the resident and their family member had brought this concern forward to the home. In response, an intervention was added to the resident's diet record data, which dietary staff use to direct care.

Lunch meal service was observed on an identified date in 2019 and breakfast and lunch meal services were observed the following day. On all three occasions, the resident was served their food without the intervention put into place that was listed in their diet record data. In an interview with dietary staff #104, they confirmed that this intervention was not followed.

Care was not provided to resident #001 as per the plan of care. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy was complied with.

The licensee's policy "Food Temperature Control" (3.2, effective August 2017), indicated that designated dietary staff were to record all temperatures on the Daily Food Temperature form.

In an interview with dietary staff #104 and #105, as well as with the DCS, they confirmed that temperatures were to be taken and documented prior to meal service when food was in the steam table.

On an identified date in 2019, a review of the 'Food Temperatures' log in the servery for a specified week revealed that no food temperatures were documented at breakfast for four days in a row.

The home's food temperature policy was not complied with. [s. 8. (1) (b)]

WN #3: 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 has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

A Complaint was submitted to the Director on an identified date in 2018 in regard to the food quality in the home. A complaint was received on behalf of resident #001 which indicated that the resident would often complain that the toast served at breakfast on the first floor was soggy. A CSR Form was completed on an identified date in 2018 and this identified that the home was aware of this concern. In an interview with the resident on

on an identified date in 2019, they confirmed this with the LTCH Inspector. This concern was also voiced by resident #007 through interview in the dining room; and in response, they had a special intervention put into place. This was confirmed by dietary staff #104.

On an identified date in 2018, the home was made aware of some concerns residents in the home were having in regard to the toast that was served at breakfast in a particular dining room. This concern was also voiced to the LTCH Inspector during inspection in the dining room on an identified date in 2019, by two residents. The home's Food Commitee Meeting minutes were reviewed for the past year which identified this concern as well.

The licensee's dietary job routines were reviewed, which indicated that dietary aide #1 (first floor) was to prepare toast between 0830-0900 hours, and dietary aide #4 (third floor) was to prepare toast between 0800-0900 hours

Food production was observed on the morning of an identified date in 2019. Dietary staff #105 was observed preparing the toast for one of the dining rooms at 0745 hours. In an interview with the staff member and the DCS, they confirmed that they toasted and buttered all of the toast for the dining room (about 5-6 loaves) around 0745 hours each morning because after that they had to work on delivering beverages. Once the toast was toasted and buttered, it was put into the steam table. Breakfast commenced at 0830 hours, as scheduled. The last table and tray service trays were served around 0850 hours, meaning their toast had been sitting for up to one hour. The LTCH Inspector observed the toast at that time; it appeared to be crisp on the crust and soggy on the inside. In an interview with dietary staff #104, they confirmed that the toast was prepared an hour prior; however, did not feel it was soggy.

Food production was observed the next morning as well. Dietary staff #105 was observed preparing the toast for one of the dining rooms at 0750 hours. Again, in an interview with the staff member, they confirmed that they did the toast at that time so that they had time to begin serving drinks.

Breakfast commenced at 0830 hours and was observed. The last table and tray service trays were served at 0900 hours, meaning that their toast had been sitting for up to over one hour. The LTCH Inspector observed the toast at that time; it appeared hard on the crust and soggy on the inside. The LTCH Inspector spoke with resident #009 who indicated that their toast was mushy and they did not eat it. Resident #001 also indicated that their toast was soggy, as they were the last table to be served.

In an interview with dietary staff #106, they indicated that there were multiple residents in the identified dining room who requested toast be made for them fresh at service each day due to it being soggy when made ahead of time. The staff member confirmed that the toast got soft on the inside due to being buttered beforehand. The DCS also observed the toast and confirmed that it was soggy and this was unacceptable to serve to residents.

Not all foods in the production system were prepared, stored and served using methods to preserve taste, appearance and food quality. [s. 72. (3) (a)]

Issued on this 26th day of April, 2019

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

Original report signed by the inspector.