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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 10, 2013	2013_214146_0016	H-002182-12, H-002195-12	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

BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156)

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): February 22, 25, 26, 27, March 6, 11, 12, 14, 2013.

During the course of the inspection, the inspector(s) spoke with the administrator, the Director of Care (DOC), registered staff, Personal Support Workers (PSW'S), dietary staff and residents.

During the course of the inspection, the inspector(s) observed resident care, dining room service, food preparation, reviewed policy and procedures and health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Dining Observation

Food Quality

Nutrition and Hydration

Personal Support Services

Reporting and Complaints

Skin and Wound Care

Snack Observation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were assessed at least weekly by a member of the registered nursing staff, if clinically indicated.
a. resident 002 has had a long-standing wound. According to the health record, weekly wound assessments were missed/not completed the weeks of November 12, 2012, December 10, and 24, 2012, January 21, 28, February 4, 2013. The wound was not assessed for a period of 27 days between January and February 2013. This information was confirmed by the health record, the DOC and the wound care nurse.
b. resident 005 had a wound discovered in January 2013. No weekly assessment was completed for 12 days and then not again for 18 days. This information was confirmed by the health record, the DOC and wound care nurse.
c. resident 006 had a wound since October 2012. Assessments reviewed since November 1, 2012 revealed that in November 2012 the assessment stated there were 2 wounds. There are no further assessments of the wound until a head to toe assessment is done 19 days later. This information was confirmed by the health record, the DOC and the wound care nurse.
d. Resident 009's records indicate a wound was discovered in January 2013. A second assessment was not done until 13 days later when the wound was documented as deteriorating. [s. 50. (2) (b) (iv)]

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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident.
a. The written care plan for resident 006 contained conflicting intervention/directions to staff. Under the problem statement of decline in decision making, the intervention stated to approach the resident from a specific direction so the person approaching can be seen; in the focus related to responsive behaviours, the intervention states to approach the resident from a different direction. This information was confirmed by the health record and the RAI coordinator.
b. The written care plan of resident 011 contained conflicting directions to staff. Under the problem statement related to ineffective coping, the direction was to approach the resident from one direction; however, under the focus related to impaired vision, the direction to staff was to approach the resident from the opposing side due to impaired vision in one eye. This information was confirmed by the health record and the RAI coordinator.
c. The written plan of care of resident 010 contained conflicting directions to staff. Under the problem statement of falls risk, the direction was to apply a front/side fastening seat belt when in wheelchair. On the same written plan of care under the same focus, the direction is also written to apply a rear fastening seat belt when in tilt wheelchair. When observed by the DOC, the resident had a side-fastening belt in place. This information was confirmed by the record and the DOC.
d. The written plan of care of resident 012 contained conflicting directions to staff. Under the focus of vision, the direction is to announce self and approach resident from a certain side due to impaired vision. On the same plan of care under the focus related to responsive behaviours, the direction is the approach resident slowly and from a different direction. This information was confirmed by the health record and the RAI coordinator.
e. The written plan of care for resident 009 contained a problem statement which stated that the resident was at low risk for falls. The same plan contained another focus which stated the resident was at high risk for falls. This information was confirmed by the record and the RAI coordinator.
f. The written plan of care for resident 006 contained a problem statement which stated that the resident was at low risk for falls. The same plan contained another focus which stated the resident was at high risk for falls. This information was confirmed by the record and the RAI coordinator.
g. The written plan of care for resident 009 contained conflicting directions regarding care devices. The written care plan directed staff that resident was not to wear shoes but to apply soft loose socks to feet. Another area of the written plan of care stated

resident was to wear proper and non-slip footwear/shoes. Progress notes in November 2012 state that resident was to wear an offloading heel boot on one foot. When observed, the resident was wearing a heel boot. This information was confirmed by the record and the RAI coordinator. [s. 6. (1) (c)]

2. The licensee did not ensure that care set out in the plan of care was provided to the resident as specified in the plan.
a. the plan states that resident 002 is to have a special device placed in one hand at all times when up. The resident was observed to be up in chair with no device in hand.
b. The plan stated to toilet resident 002 at specific times. The resident states that resident is taken to the bathroom only first thing in the morning and not again during the day.
c.The plan states to check resident 002 every 3 hours for incontinence. The resident states these checks do not take place. The information in the above 3 findings were confirmed by the resident, the health record and the staff.
d. The plan of care for resident 005 states that resident is to have pressure devices applied whenever in bed and the bed to be in the lowest position. The resident was observed in February 2013 in bed and had no devices applied. The bed was not in the lowest position. This information was confirmed by the health record and observation of the resident. [s. 6. (7)]

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

At the observed lunch meal in March 2013
a) Two residents were provided with nosey cups to assist with drinking, however, these were not indicated on the individual plans of care (residents 010 and 022)
b) The care plan for resident 023 indicated that the resident was not to receive pork. During the lunch meal, the resident was not provided or offered a second choice for the meal as the second option contained pork (pork pot pie).
c) Small portion interventions were indicated on the care plans for residents 025 and 026, however, both residents were provided with regular potions.

During the PM snack pass in March 2013:
a) Three residents requiring a diabetic diet was provided regular juice which was not consistent with their plans of care (035, 037 and 040).
b) One resident requiring a diabetic diet was provided sugar in their coffee which was

not consistent with the residents' plan of care (036).
c) One resident requiring a regular diet was provided diet juice which was not consistent with the resident's plan of care (039).
d) One resident requiring not to have caffeine was provided with caffeinated coffee which was not consistent with the resident's plan of care (038).

At the observed lunch meal in March 2013:
a) Two residents requiring a high fibre intervention of 125 ml prune juice at lunch were not provided the intervention (residents 020 and 024).
b) Three residents with nutrition interventions of 175 ml homogenized milk were not provided with this (residents 020, 022 and 023).
c) Two residents were provided with nosey cups to assist with drinking, however, these were not indicated on the individual plans of care (residents 010 and 022)
d) Resident 023 was provided with Boost supplement, however, the care plan indicated that the resident dislikes Resource 2.0 in one area and to provide 125ml Resource fruit beverage in another area.
e) Resident 027 was provided with a special cup for fluids although this was not indicated on the resident's care plan. The care plan indicated that a special plate was to be provided at all meals, however, this was not provided.
f) The care plan for resident 028 indicated that the resident was to be provided with special mugs at meals, however, this was not provided.
g) Small portion interventions were indicated on the care plans for residents 025, 026, and 032, however, all three residents were provided with regular potions.
h) The care plan for resident 030 indicated that the resident was to be provided with a mug at meals for fluids, resident does better with a mug rather than a glass; however the resident was provided with 2 glasses of fluids.
i) Resident 032 was observed entering the dining room in March 2013 where the staff had kept a meal aside; the resident's care plan indicated that the resident was to be provided with a specific menu item at each meal, however, the resident was provided with a different menu item as per the regular menu. [s. 6. (7)]

4. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change or care set out in the plan in no longer necessary or care set out in the plan has not been effective.
a) The care plan for resident 020 indicated that encouragement or cueing was to be provided during meals, however, as observed during a lunch meal in March 2013, the

resident required total feeding assistance. The change in the resident care needs was not assessed and updated in the resident's care plan.
b) The care plan for resident 029 indicated that the resident required supervision with minimal set up or assistance, however, on 2 days in March 2013, the resident required extensive encouragement and/or feeding assistance as the resident consumed a minimal amount of both solids and fluids. The change in the resident care needs was not assessed and updated in the resident's care plan.
c) Resident 033 was not reassessed and the plan of care reviewed and revised when care needs changed. The resident returned from hospital in February 2013. The DOC confirmed that there was no reassessment completed and the plan of care was not reviewed and revised related to the resident's status despite the resident returning to the home with a diagnosis indicating a need for dietary reassessment.
d) Resident 034 was not reassessed and the plan of care reviewed and revised when care needs changed. The resident returned from hospital in February 2013. As confirmed by the DOC, as of March 14, 2013, a reassessment by the Registered Dietitian was not completed and the plan of care was not reviewed and revised related to the resident's status despite the resident returning to the home with a diagnosis requiring nutritional care. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that there was an organized program of hydration for the home to meet the hydration needs of the residents.
The home Daily food and fluid intake monitoring policy (effective January 2012) in place during the inspection was not followed. Home policy indicated that staff were to track fluid not consumed and that if the resident was not meeting their calculated fluid requirements for 3 days, a referral would be made to the Nutrition Manager or Registered Dietitian using the Dietary Referral Form on Point Click Care computer system. Also, immediate action was to take place to promote consumption for those not meeting their food or fluid requirements by nursing staff until the RD can assess. The policy was not followed as confirmed by the FSM and DOC for the following residents for the time frame specified.
a) According to the fluid intake sheets for Resident 032 for a month, the resident was below the calculated fluid requirements of 1275 ml/day on all days except for three days. The DOC and FSM confirmed that there was no referral made regarding the resident's hydration status during this time.
b) Resident 020 was not meeting calculated fluid requirements of 1025 ml/day for a month on all days except four days. The DOC and FSM confirmed that there was no referral made regarding the resident's hydration status during this time.
c) Resident 030 was not meeting calculated fluid requirements of 1250 ml/day for a month on all days except five days. The DOC and FSM confirmed that there was no referral made regarding the resident's hydration status during this time.
Four residents were observed by the inspector consuming differing (less than) amount of fluids during a lunch meal in March 2013 than recorded by staff on the fluid intake sheets.
a) Resident 029 was observed having consumed no fluids, however, 400 ml was recorded on the fluid intake sheet.
b) Resident 025 was observed having consumed 100 ml, however, 550 ml was recorded on the fluid intake sheet.
c) Resident 010 was observed having consumed 300 ml, however, 550 ml was recorded on the fluid intake sheet.
d) Resident 028 was observed having consumed 175 ml however, 550 ml was recorded on the fluid intake sheet. [s. 11. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Not all residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
a) At the observed lunch meals in March 2013, resident 029 was not provided assistance throughout the meal and sat with the food in front on the table. The resident was provided only encouragement only at the end of the meal, where a few bites were taken. The resident's plan of care indicated that the resident required minimal set up or assistance.
b) Resident 030 was not provided the lunch meal on a date in March 2013 until 35 minutes into the meal. Assistance and encouragement was not provided to the resident although the resident's care plan indicated that the resident required extensive assistance.
c) Resident 032 was observed entering the dining room after lunch where the staff had kept a meal for for the resident; the meal was reheated and served but the resident refused the meal. The resident was not provided with encouragement or assistance to consume the meal. [s. 73. (1) 9.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 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.
Recipes were not found to be followed. For example, the recipe for pureed roast beef indicated that milk was to be added, however, the cook confirmed that au jus was added instead. The recipe for pureed sausage indicated that cream was to be added, however, the cook confirmed that hot water was added instead. Some recipes indicated that items were to be prepared from scratch, however, pre-purchased products were prepared instead. The Food Services Manager confirmed that not all recipes and therapeutic menus were accurate or complete. [s. 72. (3) (a)]

2. During the lunch meal in March 2013, it was observed that there was no second choice for a resident noted not to have pork. The menu indicated pork sandwich or potato strata as the regular choices for lunch. As confirmed by the dietary aide, there was no second choice without pork and only the strata was offered to resident 023. [s. 72. (3) (a)]

3. Resident 032 was observed entering the dining room after lunch in March 2013 where the staff had kept a meal for him; the resident's care plan indicated that the resident was to be provided with scrambled eggs, however, the resident was served potato strata as per the regular menu. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has not ensured that residents not be charged for non-allowable resident charges.
i. The admission package contains a consent form stating that all new residents will be charged $15.00 for an identification bracelet. This practice is confirmed by the records, the dietary manager, the administrator and resident 02. [s. 245. 1.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 101.	WN	2012_066107_0008	146
O.Reg 79/10 s. 101.	WN	2012_065169_0013	146
O.Reg 79/10 s. 101. (1)	CO #901	2012_065169_0013	146
LTCHA, 2007 S.O. 2007, c.8 s. 3.	WN	2012_105130_0021	146
LTCHA, 2007 S.O. 2007, c.8 s. 3.	WN	2012_066107_0008	146
LTCHA, 2007 S.O. 2007, c.8 s. 3.	WN	2012_070141_0015	146
LTCHA, 2007 S.O. 2007, c.8 s. 3.	WN	2012_065169_0012	146
LTCHA, 2007 S.O. 2007, c.8 s. 3.	WN	2012_065169_0013	146
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #902	2012_065169_0013	146
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #009	2012_066107_0008	146

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~~LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)~~	~~CO #001~~ BNH	2011_065169_0016	146
O.Reg 79/10 s. 69.	CO #006	2012_066107_0008	156

Issued on this 10th day of April, 2013

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

BARBARA NAYKALYK-HUNT (146)