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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	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection **September 7, 8, 9, 10, 2010**	**Inspection No/ d'inspection** 2010-165-2741-08Sep104148 2010_168_2741_07Sep085545	**Type of Inspection/Genre d'inspection** Follow Up to June 8, 2010 Review H-01248
Licensee/Titulaire **Grace Villa Limited** **284 Central Avenue** **London ON N6B 2C8** **Fax 519-672-8729**		
Long-Term Care Home/Foyer de soins de longue durée **Grace Villa Nursing Home** **45 Lockton Crescent** **Hamilton ON L8V 4V5**		
Name of Inspectors/Nom de l'inspecteurs **Lisa Vink, #168** **Tammy Szymanowski. # 165**		

The purpose of this inspection was to conduct a Follow Up to June 8, 2010 Risk Review and the inspection was to review the following previously identified findings:

- Nursing Homes Act (NHA) section 20.10 (a,b,c,e) – plan of care
- NHA section 2(1) – Fundamental Principle, rights of residents
- Long Term Care Facility Program Manual (LTCFPM) – Criterion B3.29 related to nutrition
- LTCFPM – Criterion B3.32 related to nutrition
- LTCFPM – Criterion P1.27 related to nutritional care

During the course of the inspection, the inspectors spoke with: The Administrator, Assistant Director of Nursing, the charge Registered Nurse, front line staff, Food Service Manager, Dietitian, dietary aides, family members and residents.

During the course of the inspection, the inspectors: Reviewed clinical records, reviewed policies and procedures where relevant, observed lunch and breakfast meal service, observed care and interviewed staff.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect
Minimizing of Restraints
Skin and Wound
Responsive Behaviours
Fall Prevention
Nutrition and Hydration
Dining Observation
Food Quality

17 Findings of Non-Compliance were found during this inspection. The following action was taken:
[17] WN
[10] VPC
[7] CO

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 O. Reg 79/10, s. 112.3

For the purpose of section 35 of the Act, every licensee of a long-term care home shall ensure that the

following devices are not used in the home:
3. Any device with locks that can only be released by a separate device, such a key or magnet

Findings:

1. Six identified residents were restrained with a device with locks that can only be released by a separate device on September 8, 2010, during the period of time between 11:55 and 13:05 on the 2nd and 3rd floor dining areas.
2. Restraint Observation Records dated September 8, 2010, and staff and family interviews confirm that three identified residents use a device with locks that can only be released by a separate device on a regular basis, however these residents were not observed during this inspection.

Inspector ID #:	168

Additional Required Actions:

CO # - Compliance Order #001 was served on the Licensee on September 8, 2010

Required compliance date – Immediate

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s. 101(4)

Every licensee shall comply with the conditions to which the licensee is subject.

Findings:

Section 8.1(c) of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the *Local Health System Integration Act, 2006,* reads "The Health Service Provider will: (i) conduct quarterly assessments of Residents, and all other assessments of Residents required under the Act, using a standardized Resident Assessment Instrument - Minimum Data Set (RAI-MDS) 2.0 tool in accordance with the RAI-MDS Practice Requirements included in Schedule F and will submit RAI-MDS 2.0 assessment data to the Canadian Institute for Health Information (CIHI) in an electronic format at least quarterly in accordance with the submission guidelines set out by CIHI".

1. As of September 8, 2010, three identified residents did not have their care and service needs reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the previous assessment.

Inspector ID #:	**168**

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 for, ensuring that the licensee comply with the conditions to which the licensee is subject, specifically to the completion of MDS assessments, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s. 23(1)

Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(b) appropriate action is taken in response to every such incident: and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

Findings:

1. In July 2010, the Power of Attorney (POA) for an identified resident, noted injury on the resident and reported this issue to staff. In this report the POA accused an identified staff member of this injury. The Registered Practical Nurse documented this injury and the POA's comments in the resident's plan of care and completed an Internal Incident Report, as per the homes policy. This Incident Report was forwarded to the Director of Nursing (DOC) in July 2010. the same day, the DOC reviewed and signed this report however no additional actions were taken in relation to investigating or responding to this allegation of resident abuse.

Inspector ID #:	168

Additional Required Actions:

CO # -Compliance Order #002 will be served on the licensee.
Required compliance date – November 9, 2010

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s. 24(1)

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

1. In July 2010, the POA for an identified resident, noted injury on the resident and reported this issue to staff. In this report the POA accused an identified staff member of this injury. The Registered Practical Nurse documented this injury and the POA's comments in the resident's plan of care and completed an Internal Incident Report, as per the homes policy. This Incident Report was forwarded to the Director of Nursing (DOC) in July 2010. The home has not reported, to the Director, this suspicion of abuse.

Inspector ID #:	168

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 for, ensuring that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident, that resulted in harm or a risk of harm to the resident, be immediately reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s. 6(4)

The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other

Findings:

1. An identified resident was assessed by the registered dietitian in September 2010. This assessment, which includes an evaluation of the resident's September 2010 weight, notes that the resident's skin is intact. This assessment does not complement the assessments completed by the physician or nursing staff, as at the time of the dietitian's assessment, the resident's skin was not intact.
2. An identified resident had a Physicians order in September 2010 that indicates a 72 hour food and fluid intake record be initiated however; only 1 of 3 days were completed and there was no follow up completed at the time of inspection. There was no evidence that there was a referral initiated to the Dietitian for notification of the 72 hour food and fluid record and reassessment of the resident's intake.

Inspector ID #:	168 and 165

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 for, ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that they are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O. Reg 79/10, s.110(7)

Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning.

Findings:

1. An identified resident's "Restraint Observation Form" for August 2010 includes no documentation of care provided to the resident, while restrained, on three identified occasions.

Inspector ID #:	168

WN #7: The Licensee has failed to comply with O. Reg. 79/10, 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,
(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.

Findings:

1. An identified resident has a wound, the registered dietitian has not assessed this identified need of the resident
2. An identified resident has a wound. As of September 8, 2010, this area was last assessed by a member of the registered nursing staff on August 17, 2010, which is greater than a 7 day period of time.
3. An identified resident has a wound, which was first identified in July 2010. As of September 8, 2010, there is no assessment conducted by the registered dietitian regarding this identified need of the resident.
4. An identified resident has a wound. As of September 8, 2010, this area was last assessed by a member of the registered nursing staff on August 10, 2010, which is greater than a 7 day period of time.
5. An identified resident has two wounds. The first wound was assessed by a member of the registered nursing staff, on August 11, 22, and September 3, 2010, which is not weekly. The second wound was also assessed on August 11, 22, and September 3, 2010.
6. An identified resident has a number of skin tears. These areas were assessed on August 24, 2010 and then not again until September 3, 2010.
7. An identified resident has an open area since the first week of September 2010, however there is no evidence that there was a referral to the Dietitian and there has been no nutritional assessment completed at the time of inspection.

Inspector ID #:	168 and 165

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 for, ensuring that residents who exhibit altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

CO # -Compliance Order #003 will be served on the licensee.
Required compliance date – November 16, 2010

WN #8: The Licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b)

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,
(b) is complied with.

Findings:

1. Nursing staff at the home did not follow their procedure related to Treatment Administration Record (TAR) policy 8-1-1. This procedure requires staff to chart all treatments applied by signing initials in the appropriate box corresponding to correct medication, date, and time on the TAR sheet. This procedure was not followed as evidenced by:
   - An identified resident has a treatment to be completed every 3 days. As of September 7, 2010 there was only one initial on the TAR sheet for the month of September 2010.
   - An identified resident has a treatment to be applied daily. On the September 2010 TAR there are no initials for September 4, 5, or 6, 2010.
   - An identified resident has a treatment to be completed every 3 days. There is no documentation of initials on the September 2010 TAR, for this treatment as administered, for September 1, 4, 7, 2010.

2. Staff did not follow the homes Abuse policy and procedure, last revised March 2009, related to the investigation and reporting of allegations of resident abuse, in July 2010.

Inspector ID #:	168

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 for, ensuring that staff comply with the policies and procedures of the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, 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.

Findings:

1. Resident food committee minutes dated August 24, 2010 indicate concerns that the home is disorganized during meals and not efficient.
2. The breakfast meal September 10, 2010 started twenty-two minutes late. Six of six residents in the third floor dining room interviewed by the inspector indicated that breakfast is not timely and voiced complaints of hunger while waiting for their breakfast meal.
3. At least two residents left the dining room prior to the breakfast entrée being served on September 10, 2010. An identified resident waited forty minutes prior to leaving and second resident waited fifty-three minutes prior to leaving the dining room.
4. The breakfast meal was not completed until 10:00am on September 10, 2010, one hour and thirty minutes after the assigned breakfast start time of 8:30am.

Inspector ID #:	165

Additional Required Actions:

Compliance order #004 will be served on the licensee.
Required compliance date – November 16, 2010

WN #10: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s. 11(2)

Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

Findings:

1. An identified resident did not like either choice on the menu September 8, 2010 however; the resident was only offered and provided a lettuce salad and was not offered or provided a protein alternative. The resident consumed only 25% of the salad.
2. Two identified resident were removed from the third floor dining room by nursing staff prior to being offered and provided dessert during the lunch meal September 8, 2010.
3. An identified resident was provided regular oatmeal during the breakfast meal September 10, 2010. Staff added thin milk to the cereal resulting in very runny oatmeal which did not meet the appropriate consistency as identified in her plan of care. The resident was noted to cough after each bite and as a result feeding of the cereal had to be stopped.

Inspector ID #:	165

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 with ensuring that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, 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.

Findings:

1. The plan of care for an identified resident indicates that the resident is to receive encouragement during meals and staff are to return to her table 2-3 times during the meal to ensure the resident is eating however; the resident was only approached once during the lunch meal on September 9, 2010. The resident consumed only a few bites prior to leaving the dining room.
2. The plan of care for an identified resident indicates that the resident requires total feeding and to feed him slowly however; the resident did not receive total feeding during the breakfast meal observed September 10, 2010 and intake was noted to be poor.
3. An identified resident received regular textured green beans during the lunch meal observed September 8, 2010 instead of minced texture as indicated in the Physician's order and the resident's plan of care.
4. An identified resident did not receive the high calorie cookie at the lunch meal on September 8, 2010 as indicated in the resident's plan of care.
5. An identified resident did not receive encouragement and cueing with fluids during the breakfast meal on September 10, 2010 as indicated in the resident's plan of care and fluid intake was noted to be poor.
6. Residents identified by individual plans of care as requiring assistance and encouragement throughout their meal did not receive the encouragement and assistance as required.
    - An identified resident did not receive assistance during the breakfast meal on September 10, 2010, despite her plan of care indicating she requires feeding assistance. Level of assistance was confirmed by resident's family member.
    - An identified resident did not receive encouragement with his meal September 10, 2010, until 9:40am despite his plan of care indicating staff are to return to the table 2-3 times per meal to ensure the resident is eating. The resident had poor consumption as observed by the inspector.
    - An identified resident did not receive assistance with his lunch meal September 9, 2010 until 1:20pm despite his plan of care indicating he requires assistance and for a staff member to return 2-3 times per meal to ensure resident was eating.

Inspector ID #:	165

Additional Required Actions:

CO # - Compliance order #005 will be served on the licensee.
Required compliance date – November 9, 2010

WN #12: The Licensee has failed to comply with O. Reg. 79/10, s. 26(3)

A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care.

Findings:

1. Despite concerns raised by an identified resident's power of attorney in August 2010, there has been no assessment and plan of care developed to identify and address the concern for the resident.
2. An identified resident exhibits responsive behaviours during meals. Staff members indicate this is a normal behaviour for this resident; strategies or interventions to manage this behaviour have not been developed into a plan of care for the resident.
3. There was no evidence that a nutritional assessment completed in July 2010 included an assessment of the resident's diet and swallowing. Strategies or interventions for dysphagia and safe swallowing were not developed into a plan of care for an identified resident despite recent difficulties with eating.
4. There was no evidence that a nutritional assessment of the resident's oral intake and nutritional status was completed and a plan of care was developed to address an identified resident's declining oral intake since August 2010.

Inspector ID #:	165

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 with ensuring that resident's plan of care are based on interdisciplinary assessment with respect to the residents: nutritional status, including height, weight and any risks relating nutrition care, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O. Reg. 79/10, s. 30

(2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Findings:

1. An identified resident returned from hospital in July 2010. Records from the hospital Dietitian indicate the resident's diet upon discharge was a puree texture and there were concerns; however upon return to the home the resident's diet was not changed and remained regular texture. There is no evidence that there was a nutritional assessment that included an evaluation of the resident's diet and swallowing and it was not until late July 2010 when an external consultant visited that the resident was placed on a minced texture with nectar thickened fluids. There was no Physicians order written for the diet change until August 2010.
2. An identified resident with a documented decline of fluid consumption was identified by the Dietitian in August 2010 as not meeting her individualized fluid requirements and the Dietitian recommended that staff encourage fluids. In August 2010 the resident was transferred to the hospital. On return to the home in August 2010, there was no individualized plan of care developed to address the actual risk despite previous interventions ineffective.
3. There was no evidence that there was an evaluation of the food intake studies for an identified resident as ordered by the Physician on three occasions
4. There is no evidence that there was an evaluation of the effectiveness of a treatment initiated in July 2010 despite documentation on an identified resident's medication administration record that indicates

continued refusals.

5. Documentation in an identified resident's food and fluid records for September 2010, and continued progress notes by staff in his clinical record indicate that the resident's oral consumption has declined since August 2010. Documentation by the Food Service Supervisor in August 2010 indicates the resident consumes 100% of meals and drinks 13-17 glasses of fluid per day. Current food and fluid records for September 1st -September 10, 2010 indicate a consistent decline of intake with frequent refusals of meals and an average intake of 9 glasses of fluid per day with consumption dropping to a low of 6 glasses per day. Despite the residents decline, there is no evidence that a nutritional assessment was completed that included an evaluation of the resident's food and fluid intake and nutritional status and there is no evidence that there is a plan of care developed to address the resident's hydration status and associated risks related to hydration.

Inspector ID #:	165

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 with ensuring that the registered dietitian completes nutritional assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with 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

Findings:

1. Staff do not always follow production sheets and standardized recipes. For example;
   - The recipe for flakey mandarin oranges indicates coconut however; plain oranges were served on September 8, 2010.
   - Minced oranges were very runny.
   - There were no minced green beans prepared and served as indicated on the therapeutic menu on September 8, 2010.
2. The home ran short of menu items. For example;
   - The third floor ran short of regular green beans on September 8, 2010 resulting in a resident not receiving a full portion.
   - The third floor dining room ran short of oranges September 8, 2010, with eight tables left to be served.
3. Four of six residents interviewed indicated that the food is usually overcooked, soggy or bland.
   - Macaroni beef was bland and not flavourful when tasted by the inspector on September 9, 2010.
   - Resident council minutes dated August 24, 2010 indicates residents would like foods to be more flavourful however; there have been no modifications made to recipes and production.
   - Toast is soggy as confirmed by resident statements and observed by inspector September 10, 2010. Interviews with staff indicate toast begins to be made at 7:30am however; meal service does not start until 8:30am and during the breakfast meal September 10, 2010 the last table was not served until 9:30am. Resident council minutes dated August 24, 2010 indicate resident concerns with the quality of toast.

Inspector ID #:	165

Additional Required Actions:

CO # - Compliance order #006 will be served on the licensee.
Required compliance date – November 9, 2010

WN #15: The Licensee has failed to comply with O. Reg. 79/10, 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:
11 Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

Findings:

1. There were only two feeding stools available for staff to use while feeding residents during the lunch meal September 9, 2010, on second floor. Staff members continually got up during the meal to rearrange their chair to try and provide appropriate positioning for feeding.
2. There was only one feeding stool available for staff to use while feeding residents during the breakfast meal September 10, 2010, on third floor which was insufficient for the number of residents that required feeding.

Inspector ID #:	165

Additional Required Actions:

CO # -Compliance order #007 will be served on the licensee.
Required compliance date – November 16, 2010

WN #16: The Licensee has failed to comply with O. Reg. 79/10, s. 73(2)

The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Findings:

1. An identified resident did not receive assistance with soup until nine minutes after the soup was placed in front of the resident during the lunch meal September 9, 2010.
2. One resident in the third floor dining room sat for eleven minutes with their meal placed in front of them prior to the resident receiving assistance from staff during the breakfast meal September 10, 2010.

Inspector ID #:	165

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 with ensuring that residents who require assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. An identified resident does not have a written plan of care that sets out the planned care, goals of care or directions for staff regarding identified and documented care needs of responsive behaviours. These behaviours are identified in the progress notes as early as late August 2010 and continue until September 8, 2010.
2. An identified resident has two separate statements on the document that staff refers to as her "care plan" for her fall risk status. One statement notes the resident to be at a high risk for falls while the second statement notes the resident to be at a moderate risk for falls, this does not provide clear direction to staff.

Inspector ID #:	168

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 with ensuring that there is a written plan of care for each resident that sets out the planned care, the goals of care and clear directions to staff, to be implemented voluntarily.

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.** Withdrawn - resigned July 21/11
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).

Ontario

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

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

	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Tammy Szymanowski	**Inspector ID #**	165
Log #:	H-01248		
Inspection Report #:	2010-165-2741-08Sep104148 2010_168_2741_07Sep085545		
Type of Inspection:	Follow Up		
Date of Inspection:	September 7,8,9,10, 2010		
Licensee:	Grace Villa Limited		
LTC Home:	Grace Villa Nursing Home		
Name of Administrator:	Lynette Tyler		

To Grace Villa Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007 c.8, s. 23(1)

Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(b) appropriate action is taken in response to every such incident: and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

Order:
Part 1. The licensee is required to investigate and take actions as appropriate for the allegations of abuse as reported in July 2010 by the Power of Attorney for an identified resident.
Part 2. The licensee is required to immediately investigate all future alleged, suspected or witnessed incident of abuse of a resident by the licensee or staff and take appropraite action and comply with all other requirements as provided for in the regulations, regardless of the resident(s) involved.

Grounds: In July 2010, an identified resident's Power of Attorney (POA), made allegations of abuse by a specified staff member, to a Registered Practical Nurse. These allegations were not investigated and no action was taken as a result.	
This order must be complied with by:	Part 1 November 9, 2010 Part 2 immediately

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O.Reg. 79/10, 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,
(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

Order:
1. The licensee shall have the registered dietitician assess all residents who exhibit skin breakdown, presssure ulcers, skin tears or wounds, who have not already had this actual need assessed, and implement any changes to the plan of care as a result of this assessment, related to nutrition and hydration. This includes ~~residents~~ the three identified residents.

Grounds:
Three identified residents have actual areas of skin breakdown noted as early as July 2010 and have not been assessed for these needs by a Registered Dietitian. The plan of care for these residents does not include nutrition or hydration interventions, as assessed by the registered dietitian.

This order must be complied with by:	November 16, 2010

Order #:	004	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007 c.8, 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.

Order:
1. The licensee shall prepare, submit and implement a plan for achieving compliance to address the organization of the nutrition care and dietary services for the home in order to meet the daily nutrition needs of the residents. The plan is to be submitted to Inspector: Tammy Szymanowski, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 119 King Street West, 11th floor, Hamilton ON, L8P4Y7 Fax:905-546-8255

Grounds:
The home has not addressed concerns related to disorganized meal service as identified by the resident's food committee. The breakfast meal started late and extended for ninety minutes resulting in residents voicing complaints of hunger and leaving the dining room prior to being served a complete meal.

This order must be complied with by:	November 16, 2010

Order #:	005	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007 c.8, 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.

Order:
The licensee shall ensure that all residents who require encouragement and assistance at meal times receives the required assistance as indicated in their plans of care.

Grounds:
Six identified residents did not receive the required encouragement and assistance required as indicated in their plans of care.

This order must be complied with by:	November 9, 2010

Order #:	006	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: 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.

Order:
The licensee shall ensure that all foods are prepared stored and served using methods to preserve taste, nutritive value, appearance and food quality.

Grounds:
Recipes and production sheets were not followed, quantities were not sufficient, and food quality and taste were compromised.

This order must be complied with by:	November 9, 2010

Order #:	007	**Order Type:**	Compliance Order, Section 153 (1)(a)

Ontario

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

Pursuant to: O. Reg. 79/10, 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:** **11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.**
Order: The licensee shall ensure that there are sufficient feeding stools for the number of staff feeding while assisting residents to eat.
Grounds: All staff that was assisting residents to eat did not have appropriate seating.

This order must be complied with by:	November 16, 2010

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 service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West

Ontario

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

Toronto, ON
M5S 2T5

Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this day of , 2010.	
Signature of Inspector:	[signature] resigned July 21/11
Name of Inspector:	Lisa Vink
Service Area Office:	Hamilton