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

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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
Sep 30, 2015	2015_323130_0022	H-002625-15, H-002626-15, H-002628-15, H-002629-15, H-002630-15, H-002631-15	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

Long-Term Care Home/Foyer de soins de longue durée

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

GILLIAN TRACEY (130)

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): August 26 and 27, 2015.

Follow-up to H-002113-15.
During the course of this inspection, staff and residents were interviewed, meal services were observed and clinical records were reviewed.

During the course of the inspection, the inspector(s) spoke with the Directors of Care, Manager and Supervisors of Dietary Services, Registered Dietitian (RD), dietary staff, registered staff, personal support workers (PSWs) and residents.

The following Inspection Protocols were used during this inspection:
Dining Observation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **2 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. 50. (2)	CO #008	2015_201167_0006	130
O.Reg 79/10 s. 71. (3)	CO #003	2015_201167_0006	130
O.Reg 79/10 s. 71. (4)	CO #004	2015_201167_0006	130
O.Reg 79/10 s. 73. (1)	CO #007	2015_201167_0006	130

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

A) On an identified date in 2015, resident #001 was served a pureed soup at 1205 hours, no assistance was provided, despite staff stating they required total feeding. The resident was served their entrée at 1225 hours, but they had still not received assistance with their soup. Staff assisted the resident with their entrée, but left the table to assist someone else before the resident had finished. The plan of care confirmed the resident required total assistance with eating.

B) On another identified date in 2015, resident #002 was served a regular textured tuna sandwich and coleslaw; however, staff removed the entrée before it was consumed and replaced it with a minced texture. The resident was served a regular texture dessert and a pureed dessert. Staff interviewed and the plan of care confirmed the resident was supposed to receive a minced meal.

C) On another identified date in 2015, resident #003 was served soup at 1210 hours and was served their entrée at approximately 1225 hours. The resident was not offered encouragement or assistance with eating. The resident consumed less than 50% of their meal. PSWs interviewed after the meal stated the resident would occasionally try to feed themselves but most often needed to be fed. According to the plan of care, the resident required total assistance for eating.

D) On the same date 2015, resident #004 was served their soup at 1205 hours, a PSW sat next to the resident and assisted with the soup approximately 10 minutes later, but got up from the table before the resident was finished. It was observed that the resident's bowl was removed by another PSW before the resident had finished it. The resident was served their entrée at 1220 hours, within 5 minutes a staff member sat down to assist

with feeding but got up from the table to assist someone else before the resident had finished. The resident consumed less than 50% of their meal. The plan of care and nursing staff confirmed the resident required total assistance with eating.

E) On the same date in 2015, resident #005 was served their soup, but did not receive assistance from staff. The resident's soup was partially eaten when staff removed the bowl from the table. The resident was served their entrée at 1220 hours, but did not receive assistance or encouragement throughout the meal. It was observed that the resident made an attempt to feed themselves, but less than 50% of the meal was consumed before staff cleared the plate at 1300 hours. Staff interviewed stated the resident usually needed to be fed. The plan of care indicated the resident required assistance at meals; cuing and encouragement throughout the meal and at times required partial assistance with eating.

Care was not provided to the identified residents in accordance with their plans of care. [s. 6. (7)]

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 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 were prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

Portion sizes indicated on the production sheet were not always followed, resulting in residents not being served the correct portion size.

Lunch meal service was observed on a specified date in 2015, in an identified unit dining room, in the presence of the Registered Dietitian and Supervisor of Dietary Services. The following was observed:

i. A 6oz serving was indicated for the pureed soup; however, a smaller 4oz serving was served which resulted in a smaller serving size for the residents and less nutritive value.
ii. A #10 scoop was indicated for the pureed chicken; however, a #16 scoop was used.

Breakfast meal service was observed the following day in 2015, in an identified unit dining room. The following was observed.

i) A #10 scoop was indicated for the pureed eggs; however, a #16 scoop was used. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (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. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required assistance with eating or drinking were served a meal only when someone was available to provide the assistance.

On an identified date in 2015, the following was observed during the lunch meal in an identified unit dining room.

A) Resident #001 was served pureed soup at 1205 hours, no assistance was provided until 1225 hours, despite staff stating they required total feeding.

B) Resident #003 was served soup at 1210 hours, and their entrée at approximately 1225 hours. The resident was not offered encouragement or assistance with eating. The resident consumed less than 50% of their meal. PSW staff interviewed after the meal stated the resident would occasionally try to feed themselves but most often needed to be fed.

C) Resident #004 was served soup at 1205 hours, but staff were not immediately available to provide assistance. A PSW sat next to the resident and assisted with the soup approximately 10 minutes later, but got up from the table before the resident was finished. It was observed that the resident's bowl was removed by another PSW before the resident had finished it. The resident was served their entrée at 1220 hours, but staff were not available to feed them immediately. Within five minutes a staff member sat down to assist with feeding but got up from the table to assist someone else before the resident had finished. The resident consumed less than 50% of their meal. Nursing staff confirmed the resident required total assistance with eating.

D) Resident #005 was served their soup at 1210 hours but did not receive assistance from staff. The resident's soup was partially consumed when staff removed the bowl from the table. The resident was served their entrée at 1220 hours, but did not receive assistance or encouragement throughout the meal. It was observed that the resident made an attempt to feed themselves, but less than 50% of the meal was consumed before staff cleared the plate at 1300 hours. Staff interviewed confirmed the resident needed to be fed. [s. 73. (2) (b)]

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 residents who require assistance with eating or drinking are served a meal only when someone is available to provide the assistance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal Care (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care."

On an identified date in 2015, during an observation of the lunch meal service on a specific unit dining room, nursing staff (personal support workers) were observed portioning and serving dessert to the residents. Nursing staff interviewed reported this was a routine practice for them to portion and serve the desserts on this unit when the dietary staff ran out of time. The DOC and Manager of Dietary Services confirmed it was not the role of the nursing staff to portion food. [s. 101. (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 compliance with the the conditions to which the licensee is subject, to be implemented voluntarily.

Issued on this 1st day of October, 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) :	GILLIAN TRACEY (130)
Inspection No. / No de l'inspection :	2015_323130_0022
Log No. / Registre no:	H-002625-15, H-002626-15, H-002628-15, H-002629-15, H-002630-15, H-002631-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 30, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Bakker

To ST. JOSEPH'S HEALTH SYSTEM, 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: 2015_201167_0006, CO #009;

Pursuant to / Aux termes de :

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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for residents, including #001, #002, #003, #004 and #005, is provided to the resident as specified in the plan, specifically related to assistance with eating and diet order.

Grounds / Motifs :

1. Previously issued as a compliance order in May 2015.

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

A) Resident #001 was served a pureed soup at 1205 hours, no assistance was provided, despite staff stating they required total feeding. The resident was served their entrée at 1225 hours, but they had still not received assistance with their soup. Staff assisted the resident with their entrée, but left the table to assist someone else before the resident had finished. The plan of care confirmed the resident required total assistance with eating.

B) Resident #002 was served a regular textured tuna sandwich and coleslaw; however, staff removed the entrée before it was consumed and replaced it with a minced texture. The resident was served a regular texture dessert and a pureed dessert. Staff interviewed and the plan of care confirmed the resident was supposed to receive a minced meal.

C) Resident #003 was served soup at 1210 hours and was served their entrée at approximately 1225 hours. The resident was not offered encouragement or

assistance with eating. The resident consumed less than 50% of their meal. PSWs interviewed after the meal stated the resident would occasionally try to feed themselves but most often needed to be fed. According to the plan of care, the resident required total assistance for eating.

D) Resident #004 was served their soup at 1205 hours, a PSW sat next to the resident and assisted with the soup approximately 10 minutes later, but got up from the table before the resident was finished. It was observed that the resident's bowl was removed by another PSW before the resident had finished it. The resident was served their entrée at 1220 hours, within 5 minutes a staff member sat down to assist with feeding but got up from the table to assist someone else before the resident had finished. The resident consumed less than 50% of their meal. The plan of care and nursing staff confirmed the resident required total assistance with eating.

E) Resident #005 was served their soup, but did not receive assistance from staff. The resident's soup was partially eaten when staff removed the bowl from the table. The resident was served their entrée at 1220 hours, but did not receive assistance or encouragement throughout the meal. It was observed that the resident made an attempt to feed themselves, but less than 50% of the meal was consumed before staff cleared the plate at 1300 hours. Staff interviewed stated the resident usually needed to be fed. The plan of care indicated the resident required assistance at meals; cuing and encouragement throughout the meal and at times required partial assistance with eating.

Care was not provided to the identified residents in accordance with their plans of care. (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_201167_0006, CO #006;

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 prepare, submit and implement a plan that ensures 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; specifically ensuring correct scoop sizes are used to serve food during meal service.

The plan shall include but not be limited to the following:

i. Quality monitoring to ensure ongoing compliance.
ii. Education for dietary staff portioning and serving meals.

The plan shall be submitted to Gillian.Tracey@ontario.ca no later than end of business day on September 30, 2015.

Grounds / Motifs :

1. Previously issued as a compliance order in May and October 2013, June 2014 and May 2015.

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

Portion sizes indicated on the production sheet were not always followed, resulting in residents not being served the correct portion size.

Lunch meal service was observed on August 26, 2015, in the Birch dining room, in the presence of the Registered Dietitian and Supervisor of Dietary Services. The following was observed:

i. A 6oz serving was indicated for the pureed soup; however, a smaller 4oz serving was served which resulted in a smaller serving size for the residents and less nutritive value.
ii. A #10 scoop was indicated for the pureed chicken; however, a #16 scoop was used.

Breakfast meal service was observed on August 27, 2015, in the Birch dining room. The following was observed.

i) A #10 scoop was indicated for the pureed eggs; however, a #16 scoop was used. (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2015

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 30th day of September, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

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