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

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

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

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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
Mar 8, 2016	2016_188168_0001(A1)	002081-16	Resident Quality Inspection

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

LISA VINK (168), CAROL POLCZ (156), LESLEY EDWARDS (506), MELODY GRAY (123)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 27, 28, 29, 2016 and February 2, 3, 4, 5, 8, 9, 10, 11 and 12, 2016.

This inspection was observed in part by inspector Kerry Abbott.

The following inspections were conducted concurrently with this RQI.
Critical Incidents:

001671-15 - Duty to protect and reporting certain matters to the Director
004291-15 - Duty to protect and responsive behaviours
004339-15 - Plan of care and reporting certain matters to the Director
007527-15 - Duty to protect and reporting certain matters to the Director
010576-15 - Duty to protect and responsive behaviours
011347-15 - Duty to protect, responsive behaviours and reporting certain matters to the Director
023928-15 - Duty to protect and reporting certain matters to the Director
003623-16 - Duty to protect

Complaints:
005810-15 - Falls prevention and management, dining and snack service, emergency plans and nursing and personal support services
008127-15 - Nursing and personal support services
016277-15 - Plan of care, duty to protect, continence care and bowel management and personal care
026985-15 - Dining and snack service
031760-15 - Skin and wound care and plan of care
001202-16 - Responsive behaviours
002106-16 - Plan of care

Follow Up inspections:
022817-15 - To 2015_201167_0006 (H-002113-15) CO#001 - Reg. 8. (1)
026397-15 - To 2015_265526_0015 CO#001 S6(5)
026400-15 - To 2015_265526_0015 CO#002 S6(10)
035122-15 - To LTCHA 6(7) Oct 30 2015
035123-15 - To O.Reg 72(3) Oct 15 2015
003473-16 - To 2015_201167_0006 Order # 005

During the course of the inspection, the inspector(s) spoke with the President, Administrator, Directors of Nursing (DON), Assistance Director of Nursing (ADON), registered nursing staff, personal support workers (PSWs), Manager of Engineering and Maintenance, Registered Dietitian (RD), Food Service Manager (FSM), Resident Care Co-ordinator (RCC), cooks, dietary aids, a Community Care Access Centre (CCAC) nurse, Resident Assessment Instrument (RAI) coordinator, accounting clerk, families and residents.

During the course of this inspection the inspectors; observed the provision of care

and services, toured the home, reviewed relevant documents including but not limited to: menus and production sheets, policies and procedures, meeting minutes and health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
17 WN(s)
14 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2015_265526_0015	156
LTCHA, 2007 S.O. 2007, c.8 s. 6. (5)	CO #001	2015_265526_0015	156
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_323130_0022	156
O.Reg 79/10 s. 72. (3)	CO #002	2015_323130_0022	156
O.Reg 79/10 s. 8. (1)	CO #001	2015_201167_0006	156

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

It was observed and confirmed with the Manager of Engineering and Maintenance that not all areas accessible to residents were equipped with a resident-staff communication and response system, specifically the McArthur Wing balconies, the West Wing auditorium, the chapel, the cafeteria sitting area and the conservatory areas. [s. 17. (1) (e)]

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. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods; O. Reg. 79/10, s. 72 (2).
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for, standardized recipes and production sheets for all menus and preparation of all menu items according to the planned menu.

A random audit of the production sheets and recipes was conducted in the kitchen on February 12, 2016.
A. Cook #1 was interviewed and it was identified that hot dogs were prepared for the following day. When requested a recipe for texture modified hot dogs could not be produced. The cook reported that she did not follow a recipe for minced or pureed hot dogs.
On February 3, 2016, during the Willowgrove lunch meal, the pureed hot dogs appeared to be a minced texture and the minced spinach salad was very runny.
B. Cook #2 was interviewed and it was reported that Swedish meatballs were prepared for the following day. It was confirmed that there was no recipe for minced or pureed Swedish meatballs, only that she would add sauce until it was nice and moist.
C. The recipe for Chicken Cordon Bleu indicated that the directions for texture modified chicken would be found on the following page. The cook reported that they did not use the Chicken Cordon Bleu for the minced or puree textured items but rather used diced

chicken which was then texture modified. It was confirmed that there was no recipe to direct staff in the preparation of minced or pureed Chicken Cordon Bleu.
D. Cook #2 reported that thickener was added to pureed cream corn; however, it was confirmed that the recipe for pureed cream corn did not include that thickener was to be added.
E. Cook #3 reported that the home used a no added sugar mousse cake for the entire home and for residents on a regular diet. The regular menu did not indicate that diet mousse cake was to be prepared for those on a regular diet. The cake reportedly was prepared with dairy so low lactose milk was added to the cake to puree it. The cook also indicated that low lactose mousse was prepared for those on a low lactose diet. It was unclear why low lactose milk was used for the pureed texture.
F. The snack menu was reviewed with the FSM who confirmed that the home used diet iced tea and diet crystals for the beverages at snack pass. A regular juice beverage was not available for those on a regular diet. Discussion was held with the FSM regarding the use of a diet beverage and the use of diet cake for residents on a regular diet and that many of these residents required the extra calories of both cake and juices and that they should not be given diet items unless requested or assessed by the RD.
The food production system did not consistently provide for standardized recipes and production sheets for all menus or the preparation of all menu items, according to the planned menu. [s. 72. (2)]

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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

The Resident Assessment Instrument - Minimum Data Set (RAI - MDS) assessment identifies residents with a urinary catheter to be coded as continent for the purpose of the assessment.

Resident #022 required assistance of staff to achieve their activities of daily living and had a physician's order for a urinary catheter in March 2015, due to ongoing issues with urinary retention, as recorded in the clinical record and confirmed during interview with the DON. The resident sustained a fall two days after the catheter was inserted, on the night shift, at which time their indwelling urinary catheter was dislodged. During the day shift the resident was assessed, by registered staff, for injuries related to the fall; however, the staff member did not assess the resident's urinary status nor replace the catheter, as confirmed during an interview with registered staff #140. During the provision of care on the evening shift staff identified that the resident no longer had a catheter in place and the resident was assessed to have a distended bladder. As a result the catheter was initially reinserted; however, was soon removed due to the volume and characteristics of the urine drained. The physician was notified of the situation and ordered that the resident be assessed and monitored, prior to their transport to hospital where a catheter was reinserted, before they returned to the home on the night shift.
The resident who was unable to toilet independently did not receive assistance from staff to manage and maintain continence, which was confirmed during an interview with the DON. [s. 51. (2) (c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents were fully respected and promoted, specifically to have their personal health information, within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with the Act.

On January 27, 2016, during the noon medication pass, garbage in the medication cart was noted to have opened medication pouches which contained resident names and the names of medications which were included in the pouches. Registered staff #104 was observed administering medications to residents. The staff confirmed the process of discarding pouches into the garbage and identified that it would later be disposed of with the regular garbage. The home did not fully respect the rights of residents as their personal health information was being discarded into the regular garbage. [s. 3. (1) 11.]

2. The licensee did not ensure that every resident had the right to communicate in confidence, receive visitors and consult in private with any person without interference.

On January 27, 2016, an Inspector and resident #034 were in the resident's room having a discussion with the door closed. During the discussion PSW #132 entered the resident's room without knocking or announcing their presence prior to entering. PSW #132 confirmed that they did not knock prior to entering the room and confirmed awareness of the home's expectation that this be completed. The resident verbalized that staff frequently entered their room without announcing themselves. Interview with the DON identified that this was considered "home" for the residents who resided here and the expectation that staff respect each resident's right to have visitors and communicate in confidence, especially in the privacy of their room. The DOC confirmed the expectation that staff should consistently knock before entering a resident's room and that staff were aware of this expectation.
The resident's right to communicate in confidence, receive visitors and consult in private with any person without interference was not respected. [s. 3. (1) 14.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the rights of residents are fully respected and promoted, specifically to have their personal health information, within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance the Act and to communicate in confidence, receive visitors and consult in private with any person without interference, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for the residents.

A. On January 27, 2016, the door to the shower room on Balsam Trail was noted to be unlocked.
B. On January 27, 2016, the door to the shower room on Lilac Garden was noted to be propped open with a towel.
C. On January 27, 2016, the door to the shower room on Valley Trail was propped open by a chair.
All three shower rooms contained a disinfectant cleaning product which contained a warning label which would have been accessible to anyone who entered the rooms. Registered staff #106 confirmed that the shower rooms were to be closed and locked at all times when staff were not in attendance. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the long term care home is a safe and secure environment for the residents, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (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; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

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

A. Resident #022 was dependent on staff to meet their care needs related to toileting and continence care. In March 2015, following an assessment, it was identified that the resident had some urinary retention and the physician ordered that a catheter be inserted. An indwelling catheter was inserted as ordered the same day. The plan of care in place following the insertion of the catheter in March 2015, was reviewed and did not include the presence of the catheter nor the care needs associated with the use of the device, which was confirmed following a review of the plan of care with registered staff #112. The plan of care was not based on an assessment of the resident's needs.

B. Resident #023 was identified to be at risk of falls and required extensive physical assistance of one staff for toileting and was not to be left unattended on the toilet according to the plan of care. The resident was monitored on February 3, 2016 and was observed to be left unattended on the toilet on two separate occasions. Interview with PSW #113 confirmed that the resident was left unattended on the toilet and that this was at the request of the resident. Interview with the resident identified that staff left them unattended on the toilet and that they would ring the call bell for assistance when they required assistance with a transfer on or off the toilet. Interview held with the DON identified that the resident's plan of care would be revised to reflect the resident's preference not to be attended while on the toilet, to allow privacy; however, staff would assist with transfers on and off the toilet when the requested. The plan of care was not based on the preferences of the resident. [s. 6. (2)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

The plan of care for resident #008 indicated the use of Ensure Plus three time a day was discontinued due to resident refusal. Interview with full time registered staff #121 on February 3, 2016, identified that they provided the resident with approximately half a bottle of Ensure Plus each day with medications and that the resident was compliant. Interview with RD #2 reported that the resident did not take the supplement due to refusal. Progress notes by RD #2 on January 22, 2016, indicated that the resident required total feeding; however, on February 3, 2016, PSW #122 and #123 indicated that the resident no longer required total feeding, for the past month or so, and was able to eat independently. The resident was observed on February 3, 2016, to eat independently.
Staff involved in the care of resident #008 did not collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other. [s. 6. (4) (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 the plan of care is based on an assessment of the resident and the resident's needs and preferences and to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, to minimize risk to the resident.

A. The plan of care for resident #006 identified they used a raised bed rail on the right side of the bed for bed-mobility and positioning, which was confirmed by the resident. A bed rail assessment was not found in the resident's record. The RCC confirmed that the resident was not assessed for the rail use and that their bed system was not evaluated in accordance with evidence-based practices, to minimize risk to the resident.
B. The plan of care for resident #009 identified that they required one raised bed rail on the right side of their bed for bed mobility and positioning, which was confirmed with the resident. The RCC confirmed that the resident was not assessed for rail use and that their bed system was not evaluated in accordance with evidence-based practices, to minimize risk to the resident. [s. 15. (1) (a)]

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 where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, to minimize risk to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy Abuse/Neglect of a Resident, POL/9, last revised October 11, 2015, identified that:
- "All employees have a moral and professional responsibility to ensure that any suspicion of abuse or neglect is reported immediately and to take action to prevent abuse/neglect."
- "The Manager/Supervisor investigating the alleged, suspected or witnessed incident shall notify the MOHLTC, Department Director, resident's substitute decision maker/first contact as designated by the resident immediately if incident has resulted in physical injury or pain to the resident or that causes distress to the resident that affects their health or wellbeing".
- "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 MOHLTC - becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident".

A. The home's complaints records were reviewed and identified that on an identified date in November 2015, a staff member reported resident #006 was concerned with the care given the previous night shift. The DON conducted an internal investigation which included interviewing the resident and staff regarding the allegation of abuse. Following this investigation the home received a written letter of concern from the family of resident #006 regarding the identified incident. This allegation of abuse was not reported to the Director, as confirmed during an interview with the DON.
B. On an identified date in January 2015, a staff member allegedly witnessed verbal abuse of residents #040 and #041. The staff member did not report the incident to the ADON until nine days later. The staff did not comply with the home's policy when they failed to report the incident immediately.
C. In July 2015, resident #043 reported allegations that a staff member was verbally abusing the resident and another person. This allegation of abuse was not reported to the Director as required, as confirmed during an interview with the DON.
D. In April 2015, resident #042 alleged that a staff member yelled at them and directed them to sit in water. This allegation of abuse was reported to the DON three days later and was not reported to the Director, via the Critical Incident System until four days after the DON was aware, as confirmed during an interview with the DON. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan included, at a minimum, the following: the type and level of assistance required relating to activities of daily living, customary routines and comfort requirements, known health conditions, including allergies and other conditions which the licensee should be aware upon admission, including interventions and diet orders.

Resident #021 was admitted to and discharged from the home in 2015, for a respite stay. The Goldcare care plan created during their admission included needs statements related to altered skin integrity and risk of injury from falls/falls prevention only. Interview with registered staff #105 confirmed that the care plan reviewed in Goldcare was the only plan for the resident, that it was incomplete and did not include all of the care needs for the resident. Interview with the DONs verified the expectation that respite residents had a care plan developed within 24 hours of admission and that the care plan in place at the time of discharge did not include all of the required information to direct care. [s. 24. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care plan includes, at a minimum, the following: the type and level of assistance required relating to activities of daily living, customary routines and comfort requirements, known health conditions, including allergies and other conditions which the licensee should be aware upon admission, including interventions and diet orders, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included: any mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of the clinical record for resident #050 indicated that they had multiple occasions of difficulty sleeping, hearing voices, refusal of sleep medication and ongoing behaviours. These behaviours and any potential triggers were not included in the resident’s plan of care as confirmed with the DON on February 9, 2016. [s. 26. (3) 5.]

2. The licensee failed to ensure that the RD, who was a member of the staff of the home, completed a nutritional assessment for the resident whenever there was a significant change in the resident's health condition and assess the resident's nutritional status, including height, weight and any risks related to nutrition care.

Resident #008 was noted to be at high nutritional risk. The resident had been deemed palliative since January 2015; however, their condition had improved over the past six months or so as identified during interview with registered staff #121, on February 3, 2016. The resident was now able to feed themselves with set up and encouragement unlike in the past when they required total feeding assistance. According to staff, the resident appeared better, their catheter removed and overall condition had improved. PSW staff #122 and #123 further confirmed that the resident's abilities had improved. The resident was observed eating independently in their room without any assistance on February 3 and 9, 2016.
The resident’s height was last recorded on March 28, 2011, as per interview with registered staff #121 and their weight had not been taken or recorded since January 4, 2015, as confirmed by RD #1 on February 2, 2016 and RD #2 on February 3, 2016. The RD did not complete a nutritional assessment for the resident when there was a significant change in the resident's health condition nor assess their nutritional status, including height, weight and any risks related to nutrition care. [s. 26. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, any responsive behaviours, potential behavioural triggers and variations in resident functioning at different times of the day and to ensure that the RD who is a member of the staff completes a nutritional assessment for the resident whenever there is a significant change in the resident's health condition and assess the resident's nutritional status, including height, weight and any risks related to nutrition care, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. Resident #021 was a respite admission, admitted to the home with an open area in 2015. The resident had an order for a treatment to be completed to the area of altered skin integrity daily. A review of the specific, Medication Administration Records (MAR) for treatments noted that the treatment was only signed as being completed once during their stay. Interview with registered staff #105 confirmed the signature omissions on the MAR; however, identified that in her opinion the treatment was completed and staff failed to document the intervention and the resident's response.
B. The plan of care for resident #023 identified their preference to be shaven every two days. Interview with the resident identified that they were shaven by staff twice a week on bath days and once a week by a member of their family. A review of the resident's Nursing Flow Sheets for the month of November 2015, identified that they were shaven two times only, for December 2015, it was documented that they were shaven six times and January 2016, records identified that they were shaven nine times. Interview with PSW #134 and #133 verified the resident's preference to be shaven every other day and confirmed that at a minimum the resident was shaven on bath days, when they were working; however, that this intervention was not recorded on the flow sheets as completed. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #12: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

Resident #021 was admitted to the home in 2015. A review of the clinical record did not include a skin assessment completed by registered staff within 24 hours of admission, as confirmed with registered staff #105. Progress notes at the time of admission identified that the resident's Substitute Decision Maker (SDM) reported that the resident had an open area and required treatment. (#168) [s. 50. (2) (a) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #008 was identified with more than one area of altered skin integrity and palliative wounds. The resident had been identified in their Minimum Data Set (MDS) assessments of October 26, 2015 and January 18, 2016, to have two stage I ulcers. A review of the clinical record indicated that the stage I ulcers were identified in October 2015 and assessed. A review of the clinical record did not include a reassessment of the ulcers on a weekly basis, since the October 2015, assessment. Interview with registered staff #104 and the RAI Co-ordinator confirmed the expectation of a documented weekly reassessment of all areas of altered skin integrity, including stage I wounds and that the required assessments were not recorded weekly as required. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the program included, a monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

The home had a procedure titled Vital Signs and Weight Assessment, last revised November 25, 2015, which identified that "weight is taken on admission and monthly thereafter by nursing staff. Resident weights are to be taken and reassessed monthly". Interview with the DON confirmed that weights were to be taken on a monthly basis.

The weight for resident #008 had not been taken or recorded since January 4, 2015, as confirmed by RD #1 on February 2, 2016 and RD #2 on February 3, 2016. [s. 68. (2) (e) (i)]

2. The licensee failed to ensure that the program included, a monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

The home had a procedure titled Vital Signs and Weight Assessment, last revised November 25, 2015, which identified that "Height is recorded in the Vital Signs tab in GoldCare on admission and annually". Interview held with the DONs identified that the revised procedure was not yet implemented and for this reason staff would not be monitoring resident heights annually.
i. A review of the GoldCare records for resident #025 identified that their last height was recorded in November 2011, which was confirmed with registered staff #105.
ii. A review of GoldCare records for resident #026 identified that their last height was recorded in October 2012, which was confirmed with registered staff #101.
iii. A review of GoldCare records for resident #027 identified that their last height was recorded in September 2010, which was confirmed with registered staff #101.
iv. A review of the GoldCare records for resident #008 identified that their last height was recorded in March 2011, which was confirmed with registered staff #121.

The monitoring system, in place at the time of the inspection did not ensure that residents heights were monitored annually. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the program includes, a monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter and height upon admission and annually thereafter, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: with a change of 5 percent (%) of body weight, or more, over one month; a change of 7.5 % of body weight, or more, over three months; a change of 10 % of body weight, or more, over 6 months or any other weight change that compromised the resident's health status.

A. Between July 6, 2015 and August 20, 2015, resident #002 was noted to have a weight change of 9.6 kilograms (kg) in one month or 18 %. The weight change was not assessed, actions were not taken and outcomes were not evaluated as confirmed with RD #1 on February 2, 2016. The resident was not reweighed and was not assessed by the RD until November 6, 2015.
B. Between September 1, 2015 and December 7, 2015, resident #004 was noted to have a weight change of 8.0 % over three months. On February 2, 2016, RD #1 confirmed that the resident's weight change was not assessed. [s. 69.]

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 with weight changes are assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle was a minimum of 21 days in duration.

The home's menu cycle for snacks, morning, afternoon and bedtime, was only seven days in duration. On February 2, 2016, RD #1 confirmed that the home used the same snack menu each week. [s. 71. (1) (a)]

2. The licensee failed to ensure that each resident was offered a minimum of, three meals daily.

The home submitted a Critical Incident (CI) Report to the Director to communicate that resident #033 did not receive their breakfast meal on an identified date in August 2015. PSW #129 confirmed that resident #033 did not receive their meal on the identified date. A review of the home's investigation notes and the flow sheets on the unit confirmed that seven residents, in total, did not receive breakfast on the identified date in August 2015, which was confirmed by the DON. [s. 71. (3) (a)]

3. The licensee failed to ensure every resident was offered a between-meal beverage in the morning.

On February 5, 2016, by 1130 hours, morning nourishment had not been offered to residents in the Cedar Grove home area. Interview with PSW #117 confirmed that morning nourishment were not offered or provided as required on the PSW assignment. [s. 71. (3) (b)]

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

The planned afternoon snack menu on February 9, 2016, indicated that cherry turnover cookies were to be available and offered; however, only digestive cookies were available on 4 North, and assorted cookies were available on 1 South. The menu also indicated that low calorie iced tea was to be available; however, it was not available on 4 North on February 9, 2016. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle is a minimum of 21 days in duration and that each resident is offered a minimum of, three meals daily and that every resident is offered a between-meal beverage in the morning and that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

During the Heritage Trail lunch meal on January 27, 2016, it was identified that the dessert was served without the clearing of the main course dishes. Several residents were observed still eating their main course with the dessert already served. Interview with dietary aide #100 confirmed that the meals were not served course by course. [s. 73. (1) 8.]

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 meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record was maintained and kept in the home for at least two years, in which the following was recorded, in respect to every drug that was ordered and received in the home: the date the drug was ordered, the signature of the person who placed the order, the date the drug was received and the signature of the person acknowledging receipt of the drug.

The home's drug record books on the second and fourth floors were reviewed and each order did not include the required information. The DON confirmed that the drug record did not contain the dates and signatures for every drug that was ordered and received in the home. [s. 133. 2.]

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 a drug record is maintained and kept in the home for at least two years, in which all required information is recorded, to be implemented voluntarily.

Issued on this 21st day of March, 2016

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), CAROL POLCZ (156), LESLEY EDWARDS (506), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2016_188168_0001
Log No. / Registre no:	002081-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 8, 2016
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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall create a detailed plan to identified how, where and when the home will install a communication and response system for resident and staff use in all areas accessible to residents.

This plan shall take into consideration that the older sections of the home will be a challenge to connect to the existing systems on the North and South towers and that the wiring may be incompatible.

This plan shall be submitted on or before October 2, 2016, to the planning and renewal branch, specifically Kit Chiu, Technical Specialist, MOHLTC Health Capital Division, Health Capital Investment, 1075 Bay St., 2nd Floor, Toronto ON M5S 2B1 and Inspector Bernadette Susnik at Bernadette.Susnik@ontario.ca for review and approval prior to any work of installation begins.

Grounds / Motifs :

1. This ANC was previously issued as a VPC in March 2015.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

It was observed and confirmed with the Manager of Engineering and Maintenance that not all areas accessible to residents were equipped with a resident-staff communication and response system, specifically the McArthur Wing balconies, the West Wing auditorium, the chapel, the cafeteria sitting area and the conservatory areas. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2017

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 #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that the food production system provides for, at a minimum, standardized recipes and production sheets for all menus and preparation of all menu items according to the planned menu.

The plan shall include but not be limited to the following:
i. Ensure that recipes are available for all food items including texture modified food items
ii. Identification of a process to ensure that no new menu items will be included to the menu or added to production without a recipe, for all textures required
iii. Ensure that all menu items are prepared according to the menu
iv. Education for all dietary staff involved in food preparation and delivery
v. Quality monitoring to ensure ongoing compliance, including the submission of a written report on a monthly basis to Carol.Polcz@ontario.ca, from the CEO, over the next six months, which identifies the compliance rate for all foods prepared according to the standardized recipes and actions to be taken when 100% compliance is not achieved.

The plan shall be submitted to Carol.Polcz@ontario.ca no later than end of business on April 18, 2016.

Grounds / Motifs :

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

The licensee failed to ensure that the food production system provided for, standardized recipes and production sheets for all menus and preparation of all menu items according to the planned menu.

A random audit of the production sheets and recipes was conducted in the kitchen on February 12, 2016.
A. Cook #1 was interviewed and it was identified that hot dogs were prepared for the following day. When requested a recipe for texture modified hot dogs could not be produced. The cook reported that she did not follow a recipe for minced or pureed hot dogs.
On February 3, 2016, during the Willowgrove lunch meal, the pureed hot dogs appeared to be a minced texture and the minced spinach salad was very runny.

B. Cook #2 was interviewed and it was reported that Swedish meatballs were

prepared for the following day. It was confirmed that there was no recipe for minced or pureed Swedish meatballs, only that she would add sauce until it was nice and moist.
C. The recipe for Chicken Cordon Bleu indicated that the directions for texture modified chicken would be found on the following page. The cook reported that they did not use the Chicken Cordon Bleu for the minced or puree textured items but rather used diced chicken which was then texture modified. It was confirmed that there was no recipe to direct staff in the preparation of minced or pureed Chicken Cordon Bleu.
D. Cook #2 reported that thickener was added to pureed cream corn; however, it was confirmed that the recipe for pureed cream corn did not include that thickener was to be added.
E. Cook #3 reported that the home used a no added sugar mousse cake for the entire home and for residents on a regular diet. The regular menu did not indicate that diet mousse cake was to be prepared for those on a regular diet. The cake reportedly was prepared with dairy so low lactose milk was added to the cake to puree it. The cook also indicated that low lactose mousse was prepared for those on a low lactose diet. It was unclear why low lactose milk was used for the pureed texture.
F. The snack menu was reviewed with the FSM who confirmed that the home used diet iced tea and diet crystals for the beverages at snack pass. A regular juice beverage was not available for those on a regular diet. Discussion was held with the FSM regarding the use of a diet beverage and the use of diet cake for residents on a regular diet and that many of these residents required the extra calories of both cake and juices and that they should not be given diet items unless requested or assessed by the RD.
The food production system did not consistently provide for standardized recipes and production sheets for all menus or the preparation of all menu items, according to the planned menu. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure each resident who has an indwelling urinary catheter, who is unable to manage the device some or all of the time independently, receives assistance from staff to manage and maintain continence as required to promote comfort, hygiene and urinary functioning.

The home shall provide education to all nursing staff regarding basic urinary catheter care and bladder function. This education shall include actions to be taken, as appropriate to the audience attending the education, when a catheter becomes dislodged, removed or the desired output is not achieved.

Grounds / Motifs :

1. The licensee failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

The Resident Assessment Instrument - Minimum Data Set (RAI - MDS) assessment identifies residents with a urinary catheter to be coded as continent for the purpose of the assessment.

Resident #022 required assistance of staff to achieve their activities of daily living and had a physician's order for a urinary catheter in March 2015, due to ongoing issues with urinary retention, as recorded in the clinical record and confirmed during interview with the DON. The resident sustained a fall two days after the catheter was inserted, on the night shift, at which time their indwelling urinary catheter was dislodged. During the day shift the resident was assessed, by registered staff, for injuries related to the fall; however, the staff member did not assess the resident's urinary status nor replace the catheter, as confirmed during an interview with registered staff #140. During the provision of care on the evening shift staff identified that the resident no longer had a catheter in place and the resident was assessed to have a distended bladder. As a result the catheter was initially reinserted; however, was soon removed due to the volume and characteristics of the urine drained. The physician was notified of the situation and ordered that the resident be assessed and monitored, prior to their transport to hospital where a catheter was reinserted, before they returned to the home on the night shift.
The resident who was unable to toilet independently did not receive assistance from staff to manage and maintain continence, which was confirmed during an interview with the DON. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 8th day of March, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LISA VINK

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