



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**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 soins de longue durée**

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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 24, 2016	2016_275536_0011	004053-16	Complaint

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

CATHIE ROBITAILLE (536)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 3, 7, 8, 9 and 10, 2016.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Dietitian, Food Services Manager, Food Services Supervisor, regulated and unregulated staff, dietary aides, residents and family

The following Inspection Protocols were used during this inspection:



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**Contenance Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Responsive Behaviours
Sufficient Staffing**

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

Findings/Faits saillants :



1. The licensee has failed to ensure that the plan of care related to pain was based on an interdisciplinary assessment with respect to the resident's health condition including pain and any other special needs.

On an identified date resident #001 suffered an injury. At that time the resident's plan of care for activities of daily living (ADL's) changed significantly. The plan of care was updated by the physiotherapist however, the nursing plan of care identifying the changes for ADL's was not updated until two months later. The plan of care for pain did not get updated until four months later. This was confirmed by the Director of Care. [s. 26. (3) 10.]

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 and ensuring that the plan of care related to pain is based on an interdisciplinary assessment with respect to resident's pain and any other special needs, to be implemented voluntarily.

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following:**

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 has failed to ensure that the planned menu items are offered to residents at each meal.

Week one menu identified that milk was available at breakfast, lunch and dinner daily. During observation of the lunch meal, it was noted that only an identified number of residents were offered milk. During observation of the breakfast meal, it was noted that only an identified number of residents were offered milk. Following both meal services the inspector attempted to speak with the residents not offered milk and they were unable to respond or communicate with the inspector. During interview with the dietitian, they confirmed that residents who are unable to communicate should have milk provided unless otherwise indicated in their plan of care. [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 and ensuring that the planned menu items are offered to residents at each meal, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :



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1. The licensee has failed to ensure that residents are bathed at a minimum, twice a week.

On an identified date the long term care inspector reviewed the residents bathing records on an identified home area. It was noted that between identified dates, a number of residents had documentation of only one bath in the nine day period. The Director of Care confirmed if baths or showers were not documented, they were not done. [s. 33. (1)]

Issued on this 24th day of June, 2016

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

Original report signed by the inspector.