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 prévue 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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 11, 2019	2019_570528_0012	010052-18, 029233-18, 032423-18	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

CYNTHIA DITOMASSO (528), MICHELLE WARRENER (107)

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): March 22, 25, 27, 28, 29, and April 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 2019.

This Complaint Inspection included the following:
Complaint Log #010052-18 and 029233-18 related to sufficient staffing; and log #032423-18 related to dining and snack service.

This inspection was completed concurrently with Follow Up Inspection # 2019_541169_0012, Critical Incident Inspection 2019_ 549107_0007 and Complaint Inspection # 2019_541169_0011.

Non-compliance related to Ontario Regulation 79/10 s. 8(1)(b) identified during inspection of log # 032423-18 and 025406-18 is included in this inspection report and issued as a voluntary plan of correction.

Non-compliance related to Ontario Regulation 79/10 s. 30(2) identified during this inspection is included in Critical Incident Inspection 2019_549107_0007 and issued as a written notification.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Directors of Care (DOC), the Assistant Director of Care (ADOC), the Human Resources Manager, the Manager of Housekeeping and Laundry, the Physiotherapist, the Resident Care Managers (RCM), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW)/health care aides (HCA), Registered Dietitians (RD), the Food Service Managers (FSM), dietary aides, residents and families.

During the course of the inspection, the inspector(s) also observed the provision of care and services, reviewed documents including but not limited to: clinical records, staffing schedules, meeting minutes, staffing plan, menus, and job routines.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
0 AMP(s)

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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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 a change of five percent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #044 had a goal weight range identified in their nutritional plan of care. The resident had a significant weight change over one month that was flagged as a significant change in the Point Click Care (PCC) computerized system in December 2018. Action was not taken to address the weight change until Registered Dietitian #195 assessed the resident over a month later. Several weeks after the RD assessment, the resident was flagged as having additional significant weight change.

The resident was reviewed by Food Services Supervisor (FSS) #198 as part of the quarterly review in December 2018, where the significant weight change was noted, however, action was not taken to address the weight change. The FSS confirmed that the resident was not referred to the Registered Dietitian for assessment and the plan was to continue with the current dietary plan of care.

Documentation in the resident's progress notes did not make reference to the significant weight change and did not include an interdisciplinary assessment of the significant weight change by registered nursing staff. No action was taken until Registered Dietitian #195 assessed the resident.

During interview in April 2019, with RPN #196, they stated that the nursing staff were

responsible for the initial assessment of resident weight changes (including current food and fluid intake, patterns, changes in condition, and medication changes) and that the RPN would communicate this information using the Dietitian Referral form found in the PCC computerized system. RPN #197 stated they would complete a Dietitian Referral for the significant weight change.

The home's policy, Nutritional Assessment & Risk and Dietary Referral/Requisition FOO-POL/3, effective August 1977, last revised in November 2017, directed staff to send a referral to the Registered Dietitian using the 'SJV-Dietary Referral/Requisition form' on PCC for weight changes. The policy also indicated a weight variance report for significant weight variances was automatically generated and that the Dietitian was responsible for routinely reviewing the Weight and Vitals report in PCC. Director of Care #186 and RPN #196 stated that a referral to the Registered Dietitian was also required (as indicated in the home's policy) to ensure an interdisciplinary approach to the assessment of significant weight changes.

During interview, Registered Dietitian #195 confirmed that a referral had not been completed related to the resident's significant weight change and that action had not been taken to address the significant weight change until over a month later. [s. 69. 1.]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or system, the policy or system was complied with.

A. In accordance with O. Reg. 79/10, s. 68(2)(a) and in reference to Ontario Regulation 79/10, s. 68(2)(b)(c) the licensee was required to have policies and procedures relating to nutrition care, dietary services, and hydration that identified risks related to nutrition care, dietary services and hydration with the implementation of interventions to mitigate and manage those risks.

Specifically, staff did not comply with the licensee's policy, Nutritional Assessment & Risk and Dietary Referral/Requisition FOO-POL/3, effective August 1977, last revised November 2017.

The home's policy identified that a Dietitian referral would be sent using the Point Click Care SJV Dietary Referral/Requisition form for specific situations/conditions.

Resident #006 had a plan of care that identified the resident had a nutritional risk and was being followed by Food Service Supervisor #140.

Progress notes in December 2018, identified the resident was displaying symptoms more than usual; in January 2019, the resident was displaying symptoms a lot throughout the meal; and in February 2019, the resident continued to display symptoms.

During interview with RPN #138 they stated that around December 2018 or January 2019, they noticed that the resident was displaying symptoms a lot and the episodes were mainly around meals.

At an identified meal in March 2019, Inspector #107 observed the resident significantly displaying symptoms on an off throughout the meal. Health Care Aide staff assisting the resident with activities of daily living that day were not their regular care giver and could not provide history to the Inspector.

Documentation in the resident's progress notes in March 2019, did not include any reference to the symptoms at the meal, nor an assessment of the resident in relation to the symptoms.

During interview with Registered Dietitian #139 in April 2019, they confirmed they had not re-assessed the resident in relation to the symptoms and that a referral had not been made to the Registered Dietitian to have the resident re-assessed. The resident was being followed by Food Service Supervisor #140 and had not been assessed by the Registered Dietitian since May 2018.

The Registered Dietitian confirmed that the documented symptoms in the progress notes and observed symptoms should have prompted a referral or reported back to the Registered Dietitian for re-assessment of the resident, as outlined in the home's policy. (107)

B. In accordance with O. Reg. 79/10, s. 68(2)(a) and in reference to O.Reg. 79/10, s. 68(2)(b)(c) the licensee was required to have policies and procedures relating to nutrition care, dietary services, and hydration that identified risks related to nutrition care, dietary services and hydration with the implementation of interventions to mitigate and manage those risks.

Specifically, staff did not comply with the licensee's policy, Nutritional Assessment & Risk and Dietary Referral/Requisition FOO-POL/3, effective August 5, 1977, last revised November 23, 2017.

The policy directed the Food Services Supervisor to follow residents at low and moderate nutritional risk according to the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) process and timelines and to send a referral to the Registered Dietitian if the nutritional risk status changed. The policy identified high nutrition/hydration risk issues, including but not limited to: significant weight change, recent changed appetite, and abnormal lab values related to nutrition.

The policy also directed all staff to refer to the Registered Dietitian using the SJV-Dietary Referral/Requisition form on PCC for (but not limited to): weight loss; poor appetite; poor fluid intake; altered skin integrity; choking; dysphagia; return from hospital; and change in status.

Resident #044 was reviewed by Food Services Supervisor #198 in December 2018, for the resident's RAI-MDS review. The FSS identified a significant weight change, which did not meet the resident's goal weight range, a change in food and fluid intake and abnormal diagnostic testing. A referral to the Registered Dietitian was not initiated and

the plan was to continue with the current dietary plan of care.

During interview with FSS #198 they confirmed they did not refer the resident to the Registered Dietitian. The FSS identified the resident as a Nutritional Risk on the SJV-Nutrition/Hydration Risk Assessment V.2. tool in the December 2018, screening and did not flag the significant weight change or change in diagnostic testing that would categorize the resident as a change in nutritional risk on the tool.

The home's policy also identified that the Dietitian referral would be sent for specific situations/conditions.

Resident #044 had documentation in their progress notes in March 2019, that the resident had a change in food intake and displayed symptoms. In March 2019, the resident was noted to have a change in symptoms that was ongoing. A referral to the Registered Dietitian was not initiated related to the the change in symptoms.

Registered Dietitian #195 confirmed they had not received a referral. However, after observing the resident in April 2019, the Registered Dietitian completed an assessment and changed the resident's diet texture and their fluid consistency. (107)

C. In accordance with O. Reg. 79/10, s. 68(2)(a) and in reference to O.Reg. 79/10, s. 68(2)(b)(c) the licensee was required to have policies and procedures relating to nutrition care, dietary services, and hydration that identified risks related to nutrition care, dietary services and hydration with the implementation of interventions to mitigate and manage those risks.

Specifically, staff did not comply with the licensee's policy regarding, "Capillary Blood Glucose Monitoring and Management of Hypo/Hyperglycemia", effective March 1, 2012 and last revised December 2017.

The policy directed staff to take specific actions in specific situations.

Resident #055 had the following blood sugars and treatments identified in Point Click Care (PCC) progress notes and vitals:

From June to August 2018, six occasions were identified where the resident was documented as having an abnormal blood sugar however, interventions provided were

not consistent with the home's policy.

During interview with Registered Dietitian (RD) #139 they stated that the treatments provided to resident #055 (as identified in the resident's progress notes on the six identified occasions) did not follow the home's policy.

During interview with DOC #186 they acknowledged that the home's policy was not followed by staff providing care to resident #055. On the six identified occasions, staff did not follow the interventions identified in the policy related to timelines for re-checking the resident's blood sugar level after providing treatment, as outlined in the policy.

E. In accordance with Ontario Regulation 79/10, s. 48 (1)1 and s. 49 (1), the licensee was to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy, Falls Prevention Management, last revised April 2018, which stated "Head injury routine (Nursing Standard- Head Injury Routine HIR) will be followed if the resident strikes their head, is suspected of striking their head, or for an un-witnessed fall where the resident is unable to accurately report whether they hit their head". Staff also did not comply with the policy, Head Injury Routine Record, last revised March 2012, which identified the assessment schedule for the Head Injury Routine (HIR) to be every half hour for two hours; every one hour for fours; and every four hours for 24 hours.

Critical Incident System (CIS) #2975-000060-18, log #025406-18, was submitted in September 2018, for an incident that caused an injury to resident #022 for which the resident was taken to hospital and which resulted in a significant change in their health status.

A review of resident #022's progress notes in September 2018, described resident #022 as having an unwitnessed fall and was sent to hospital over an hour later. In an interview with Registered Nurse (RN) #150, in April 2019, they confirmed they did not do a Head Injury Routine (HIR) in their assessment of the resident after the fall, and before the resident was transferred to the hospital.

In an interview with the Resident Care Manager (RCM) #153, in April 2019, it was identified that a HIR, should have been initiated as soon as possible, following an unwitnessed fall or a witnessed fall with head injury.

In an interview with the Director of Care (DOC) #186, in April 2019, it was verified that the HIR schedule for the first two hours after a fall, was every half hour; and that resident #022, would have had two assessments completed from the time they fell to the time they were sent to hospital.

The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with. (748) [s. 8. (1) (a),s. 8. (1) (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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or system, the policy or system is complied with, to be implemented voluntarily.

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,
(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; O. Reg. 79/10, s. 51 (2).
(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; O. Reg. 79/10, s. 51 (2).
(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).
(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; O. Reg. 79/10, s. 51 (2).
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).
(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; O. Reg. 79/10, s. 51 (2).
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence; and each resident who was incontinent had 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 was implemented.

Review of the MDS Assessment, from January 2019, for resident #032 identified that the resident was continent of both bowel and bladder. The written plan of care directed staff to provide extensive assistance activities of daily living.

In April 9, 2019, the resident was observed to be in bed eating breakfast. Interview with the resident at that time, revealed that they liked to get out of bed before breakfast to use the bathroom. Over two hours later, PSW #178 was observed provided morning care to the resident. Interview with PSW #178 confirmed that the resident had been incontinent of bladder.

Review of the plan of care revealed that the resident was readmitted to the home, in March 2019. The re-admission assessment of the resident documented that the resident's continence level had changed; however, did not include a clinically appropriate assessment related to their change in continence level.

Review of the home's policy "Continence Care and Bowel Management Program", revised January 2018, directed nursing staff to complete a clinical assessment of bowel and bladder on admission and with a significant change in health status. Based on the clinical assessment an individualized care plan would be developed and implemented.

Interview with PSW #178 and RPN #119 confirmed that the resident had a change in their continence level. Interview with RPN #119 and RCM #193 confirmed that resident #032 had a change in their level of continence but a Continence Assessment was not completed, as required; and interventions had not been identified to determine, how the staff were to promote and manage the resident's bladder and bowel continence. [s. 51. (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 the following:
(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 required, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

A. On an identified day in April 2019, on a specific home area, the medication cart was noted to be outside of the dining room unlocked and unattended. Seven residents were seated inside the dining room and six residents were seated in the common area. The registered staff was not present at the time and the LTC Homes Inspector #528 was able to open the medication drawers. When RPN #162 returned to the cart, they confirmed that they had left the cart unattended and unlocked when they went to help a resident in their room. Interview with RPN #162 confirmed that the medication cart should have been locked and secured when unattended.

B. On an identified day in April 2019, LTC Homes Inspector #107 came to an identified lounge area and noticed an unattended medication cart that was positioned beside numerous residents that were sitting watching television. The medication cart was left with a prescription medication pouch on the top of the cart and the cart drawers were left unlocked.

Registered Practical Nurse (RPN) #141 had left the cart to assist a resident. The resident was in the small room off the lounge and the RPN had their back to the cart. The RPN was re-positioning the resident and was away from the cart without visual sightline for at least five minutes. Inspector #107 asked the RPN about the unlocked cart and the RPN confirmed they should have locked the cart and put the medications away.

The licensee failed to ensure that drugs were stored in a medication cart that was secure and locked. [s. 129. (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 drugs are stored in an area or medication cart that is locked and secured, to be implemented voluntarily.

WN #5: 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. (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 staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #098 so that their skin and wound assessments were consistent with each other.

A. Review of the plan of care for resident #098 identified that they had an area of altered skin integrity. Review of the MDS assessment from September and December 2018, revealed that the resident had an area of altered skin integrity.
Review of the weekly wound assessments from August 2018 to March 2019, revealed multiple areas of altered skin integrity that registered staff were documenting regarding their assessments findings.
Interview with RN #109, confirmed the area of altered skin integrity and stated that due to the location, the interdisciplinary team had classified other areas in error. Interview with the Wound Care Champion, confirmed that the weekly wound assessments were not consistent with each other, in relation to the location of the altered skin integrity for resident #098. (528)

B. The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #044 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other related to the resident's food and fluid intake.

Documentation related to food and fluid intake was not consistent between resident #044's progress notes and the food and fluid intake records, resulting in the inability to flag changes in the resident's intake. Progress notes and food and fluid intake records were reviewed for resident #044 between December 2018 and March 2019, and sixteen examples were noted where the data was inconsistent between the records.

Review of the food and fluid intake records and progress notes, and interview with DOC #186 in May 2019, confirmed that the information was inconsistent. The assessment of resident #044's food and fluid intake was not consistent for records documented in the progress notes and food and fluid intake records for the same meal. (107) [s. 6. (4) (a)]

WN #6: 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 :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Review of Complaint log #029233-18 and 010052-18, submitted in 2018, identified care concerns for residents. In a follow-up interview with the complainant in March 2019, the complainant revealed that they were concerned with the staffing in the home being insufficient.

Review of the plan of care for resident #008 identified that they required assistance of two staff for bathing twice a week on day shift. The Nursing Flow Sheets from January to March 2019, were reviewed and indicated that the bathing was not consistently documented twice per week, on one occasion in January 2019, one occasion in February 2019, and three occasions in March 2019.
Interview with RPN #110, confirmed that when PSW/HCA staff were unable to come to work and the shift could not be filled, bathing was sometimes missed and not made up.
Interview with HCA #177 confirmed that when the home worked short, they were unable to get all the resident's bathed. Interview with RPN #110 and HCA #177 could not confirm that bathing was made up for the dates listed.
Interview with DOC #188, confirmed that when baths were missed it was the expectation that PSW/HCA report the missed bath to registered staff, it was to be documented in PCC, and then made up within 24 hours. [s. 33. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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).
(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).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of, a between-meal beverage on an identified evening.

On an identified day in February 2019, residents were not offered a beverage or snack on an identified home area. RPN #119 stated they usually provided the snack service while completing the medication pass. That day, in February 2019, RPN #119 was required to work on two different floors due to staffing shortages and they were unable to deliver the snack due to going to the other floor. The RPN stated they had informed Resident Care Manager #193 that the nourishments were not provided. The RPN stated that they had asked PSW #157 to document in the Food and Fluid Intake records to reflect that the snack pass had not been offered to residents.

During interview with PSW #157, the PSW that was working in February 2019, they confirmed that residents were not offered a snack or beverage on the identified day.

Nine residents on the home area were identified as nutrition risk, three residents required textured modified, five residents required a modified diet and eight residents required an intervention to increase their caloric intake. According to documentation on the resident's food and fluid intake records, none of the residents identified at risk were recorded as receiving snack on the identified day.

Documentation on 18 food and fluid intake flow sheets reviewed on the home area recorded for the evening snack on the identified day February 2019 (signed by PSW #157), reflected that the residents did not consume a beverage or a fluid. The documents were recorded as "0" not taken, for the following residents: #042, #043, #063, #048, #049, #034, #050, #051, #052, #053, #060, #046, #047, #042, #043, #061, #003, #035, #032, and #062.

During interview in April 2019, residents #042 and #045 who resided in the home area, stated that they were not routinely offered a snack and/or beverage but would likely take one if it was offered by staff. Documentation on the residents' food and fluid intake records reflected that food was not routinely taken at the snack pass. [s. 71. (3)]

WN #8: 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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all foods were prepared and served in a manner that prevented contamination at the breakfast meal on an identified day April 2019.

At an identified time, resident #008 was observed eating their meal alone in the dining room as they had chosen to get up later. Resident #008 told Inspector #107 that they were still hungry and wanted additional food. HCA #129 was notified and proceeded to prepare toast with jam and butter for the resident. The HCA was in the servery preparing food for resident #008 without wearing a hair net. The staff member's hair was not short. [s. 72. (3) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home provided residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On an identified day in April 2019, for an identified time, resident #030 was observed in bed sleeping, their head raised approximately 45 degrees, with a full breakfast tray.
i. Review of the plan of care for resident #030 revealed that they were at nutritional risk and required assistance when eating in their room and directed staff to ensure specific interventions were in place.
ii. At an identified time, HCA #179 entered the room and asked the resident if they still wanted their meal, the resident replied "yes" and went back to sleep. HCA #179 then left the room. A few minutes later, HCA #196, entered the room and assisted resident #030 with specific interventions. The resident then began eating their breakfast meal.
iii. Interview with HCA #179 confirmed that the home was working with one less HCA/PSW than their desired complement. They stated that they had brought the resident their breakfast tray around approximately 45 minutes before assistance was provided.

Resident #030 was not provided with the assistance as required in their plan of care. [s. 73. (1) 9.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept up to date and maintained for each resident of the home.

Written records, including flow sheets for personal care and food and fluid intake, were not maintained to include the month or year for 11/11 residents reviewed for two months in the year.

Review of personal care and food and fluid intake records reviewed did not include which month or year the data was recorded, however, in discussion with RPN #151 and #152 they determined that the records were likely recorded in January and February of 2019.

During discussion with the Administrator in April 2019, they stated that a specific position had been off in January and February 2019 and they were the person responsible for updating the records with the current month and year prior to the records being completed by front line care staff. [s. 231. (a)]

Issued on this 14th day of June, 2019

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

Ministry of Health and Long-Term Care

Order(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

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) :	CYNTHIA DITOMASSO (528), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2019_570528_0012
Log No. / Registre no:	010052-18, 029233-18, 032423-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 11, 2019
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6
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 :	Mieke Ewen

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 69.1.

Specifically, the licensee must:
a) Ensure that all residents with significant weight changes have an interdisciplinary assessment of the significant weight change and that action is taken to address the weight change based on the resident's needs.
b) Provide education to Food Service Supervisors on the home's policies and procedures related to screening residents at low and moderate nutrition risk, and the process for when to refer to the Registered Dietitian for further assessment.
c) Provide education for all front line nursing staff on the home's policy and procedure for referral to the Registered Dietitian and the interdisciplinary process for the assessment of weight changes.
d) Conduct an audit, at a schedule of the home's choosing, to ensure that residents with significant weight change have an interdisciplinary assessment of the weight change and that action is taken to address the weight change.
e) Keep a documented record of the audit.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents with a change of five percent of

body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #044 had a goal weight range identified in their nutritional plan of care. The resident had a significant weight change over one month that was flagged as a significant change in the Point Click Care (PCC) computerized system in December 2018. Action was not taken to address the weight change until Registered Dietitian #195 assessed the resident over a month later. Several weeks after the RD assessment, the resident was flagged as having additional significant weight change.

The resident was reviewed by Food Services Supervisor (FSS) #198 as part of the quarterly review in December 2018, where the significant weight change was noted, however, action was not taken to address the weight change. The FSS confirmed that the resident was not referred to the Registered Dietitian for assessment and the plan was to continue with the current dietary plan of care.

Documentation in the resident's progress notes did not make reference to the significant weight change and did not include an interdisciplinary assessment of the significant weight change by registered nursing staff. No action was taken until Registered Dietitian #195 assessed the resident.

During interview in April 2019, with RPN #196, they stated that the nursing staff were responsible for the initial assessment of resident weight changes (including current food and fluid intake, patterns, changes in condition, and medication changes) and that the RPN would communicate this information using the Dietitian Referral form found in the PCC computerized system. RPN #197 stated they would complete a Dietitian Referral for the significant weight change.

The home's policy, Nutritional Assessment & Risk and Dietary Referral/Requisition FOO-POL/3, effective August 1977, last revised in November 2017, directed staff to send a referral to the Registered Dietitian using the 'SJV-Dietary Referral/Requisition form' on PCC for weight changes. The policy also indicated a weight variance report for significant weight variances was automatically generated and that the Dietitian was responsible for routinely reviewing the Weight and Vitals report in PCC. Director of Care #186 and RPN #196 stated that a referral to the Registered Dietitian was also required (as indicated in the home's policy) to ensure an interdisciplinary approach to the

assessment of significant weight changes.

During interview, Registered Dietitian #195 confirmed that a referral had not been completed related to the resident's significant weight change and that action had not been taken to address the significant weight change until over a month later. [s. 69. 1.]

The order is made up on the application of the factors of severity (3), scope (1), and compliance history (3), with Voluntary Plan of Corrections (VPC) issued in October 2017, during the Resident Quality Inspection (2017_542511_0011) and in March 2016, during the Resident Quality Inspection (2016_188168_0001). (169) (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

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
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 du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 11th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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