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 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
Oct 3, 2017	2017_673554_0020	018474-17	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Hope Street Terrace
20 HOPE STREET SOUTH PORT HOPE ON L1A 2M8

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

KELLY BURNS (554)

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): September 05-08, and September 12, 2017

Intake #018474-17

Summary of Intake:
1) #018474-17 - Complaint - care related concerns, and notification of substitute decision maker related to change in resident health status.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Food Services Coordinator, Registered Dietitian, Registered Nurse (s), Registered Practical Nurse(s), Personal Support Worker(s), Family and the resident.

During the course of the inspection, the inspector toured the long-term care home, observed staff to resident interactions, reviewed clinical health records, reviewed licensee specific policies, specifically Skin and Wound Care Management Program.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the SDM (Substitute Decision Maker), if any, and the

designate of the resident/SDM was given an opportunity to participate fully in the development and implementation of the plan of care.

Intake #018474-17:

Resident #001 was admitted to the long-term care home on an identified date. Resident #001 had a history which included cognitive impairment.

The clinical health record was reviewed, by the inspector, for a period of one month. The clinical health record provided documented details specific to a change in resident #001's health condition.

Substitute Decision Maker indicated, to inspector, that he/she arrived at the long-term care home, on an identified date, to visit with resident #001 and found that resident #001 had a change in condition. SDM indicated that Registered Nurse (RN) #106 indicated that resident had identified symptoms. SDM indicated that RN #106 stated that they (the registered nursing staff) had not yet contacted a physician regarding the change in resident #001's condition. SDM voiced "displeasure" at not being notified of the change in resident #001's health condition.

Registered Nurse #106 indicated, to inspector, that he/she worked on a specific shift on an identified date, it was communicated to him/her during shift report, by Registered Practical Nurse #103, that resident #001 had been experiencing specific symptoms. RN #106 indicated that RPN #103 had indicated the resident's SDM had not been notified of the change in resident #001's condition.

Registered Practical Nurse (RPN) #103, indicated to inspector, that he/she worked day shift on an identified date, that it was communicated to him/her from registered nursing staff from the previous shift, that resident #001 was experiencing an identified symptom. RPN #103 indicated that he/she had been told by staff that resident #001 had been experiencing identified symptoms. RPN indicated that he/she had assessed resident, noting specific symptoms. RPN #103 indicated that resident #001 continued to experience symptoms, which he/she reported to the oncoming shift. RPN #103 indicated that he/she had not contacted the SDM for resident #001.

Registered Nurse #106 indicated that SDM for resident #001 expressed displeasure at not being notified of resident's change in condition on the identified date. RN #106 indicated SDM requested that resident be transferred to hospital for assessment and

treatment.

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 there is a process in place and monitored, ensuring the SDM (substitute decision make), if any, and the designate of the resident/SDM was given an opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: 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 24 hour care plan identified the resident and included, at a minimum, the type and level of assistance required relating to activities of daily living; and skin condition and interventions.

Intake #018474-17:

Resident #001 was admitted to the long-term care home on an identified date. Resident #001 had a history which included cognitive impairment.

The clinical health record was reviewed, by the inspector, for a period of one month, with the following documented:

Progress Notes:
- On an identified date– Resident #001's Substitute Decision Maker (SDM) indicated, to registered nursing staff, that resident required supervision and assistance for all activities of daily living.

Head to Toe Skin Assessment (admission date), documented by Registered Nurse (RN) #106), identified resident's risk related to his/her skin condition.

The 24 hour written care plan reviewed (by the inspector), for resident #001, did not identify the type and level of assistance required for activities of daily living (ADL), specifically assistance required for personal hygiene, oral hygiene, dressing, and toileting, nor did the 24 hour care plan identify resident #001's skin condition and associated interventions.

Registered Nurse #105 and #106, as well as the Director of Care, and Administrator, all reviewed the 24 hour written care plan, for resident #001, and concluded that the care plan did not identify type and level of assistance required for ADL's, skin condition and interventions.

Registered Nurses, the Director of Care and the Administrator indicated the 24 hour care plan should identify the type of ADLs and assistance required for that resident, and if a resident has an identified skin condition, there should be interventions in place specific to the care of the individual resident. [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 there is a process in place and monitored, ensuring that the 24 hour care plan must identify the resident and must include, at minimum, the type and level of assistance required relating to activities of daily living; and skin condition and interventions, to be implemented voluntarily.

Issued on this 4th day of October, 2017

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

Original report signed by the inspector.