Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Jan 21, 2016	2016_328571_0001	033595-15	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

STREAMWAY VILLA
19 JAMES STREET WEST COBOURG ON K9A 2J8

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

PATRICIA MATA (571), SAMI JAROUR (570), SARAH GILLIS (623)

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 4, 5, 6, 7, 8, 11, 12, 13 and 14, 2016

During the course of the RQI inspection the following intakes were completed:

Log # 011887-15 related to a complaint regarding personal care concerns, administration of medication, and Resident Bill of Rights.

Log(s) #026821-15 and log #010868-15 related to critical incidents the home submitted related to responsive behaviours and duty to protect.

Log #008958-14 related to a complaint regarding a resident being denied admission to the home.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), RAI Co-ordinator, Clinical Care Co-ordinator, Nutritional Care Manager/Environmental residents, Services Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, house keepers, dietary staff, BSO RPN and family members

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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). 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. 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).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

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

During the observation of the lunch meal on January 4, 2016 the following was observed by the inspector:
- Residents #028, #048 and #027 were provided their main course before finishing their soup.
- PSW #114 continued to assist Residents #028 and #048 with their soup while their main courses remained on the table untouched; Resident #027 sitting at same table, required encouragement and intermittent assistance by PSW #114 with the soup while the main course remained on the table untouched.

During the observation of the lunch meal on January 5, 2016 the following was observed by the inspector:
- Residents #028, #048, seated at table #4, were provided their main course before finishing their soup.
- A Dietary Aide placed resident #027's main course on table #4 and stated "I will just put this here until resident #027 finishes his/her soup"
- Residents #035, #049 and #050, seated at table #7, were provided their main course before finishing their soup.
- residents #029, #041 and #051, seated at table #9, were provided with main course while soup sat on the table untouched as they required assistance
- PSW #116 confirmed that sometimes the main course is served to residents before the soup is finished.

- PSW #114 confirmed that residents at table #4 were provided with main course before their soup was finished.

On January 11, 2016 at 1215 hours Inspector #623 observed nine residents seated at tables #4, 7, and 9 eating their soup while the main course, on tables in front of residents, remain untouched. Resident #041 seated at table #9 still had soup and a main course in front of him/her as well as dessert; the PSW went straight to the main course and did not feed any soup to the resident.

The current plans of care for the aforementioned residents were reviewed and no indication that any of the residents should be served more than one course at a time at meals was found.

In an interview with the Nutritional Care Manager on January 12, 2016, he explained that the expectation of the home and as per policy was that residents should be provided their meals course by course. [s. 73. (1) 8.]

2. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

In an interview on January 5, 2016, a family member of resident #029 indicated that sometimes the resident must wait to be assisted at meals even though the meal has already been served.

A review of the current plan of care for the following residents indicated:

-Resident #029 is at high nutritional risk related to significant weight loss as a result of declined intake. Resident #029's plan of care also indicated that setup help from staff, cuing and encouragement may be needed; some days the resident requires feeding.

-Resident #049 is at moderate nutritional risk and requires total assist; the resident is fed every meal by a PSW.

-Resident #050 is at high nutritional risk and requires extensive assistance; requires a lot of encouragement and cuing from staff.

-Resident #048 is at high nutritional risk and requires constant encouragement or physical assistance for eating; total dependence requires full staff assistance.

-Resident #027 is at moderate nutritional risk and requires one staff to guide and cue food to the resident's mouth as needed, sits at an assistive table.

-Resident #028 is at moderate nutritional risk and requires extensive assistance with eating, Staff need to hand items and cue to eat. If the resident won't feed themselves, staff will attempt to do this.

-Resident #041 is at moderate nutritional risk and requires one person physical assist; at times needs to be fed as the resident lacks motivation and focus to stay on task.

-Resident #035 is at high nutritional risk and requires constant assistance with eating; the resident is to be fed by staff.

-Resident #051 is at moderate nutritional risk and requires setup help; often times will needs cuing to stay on task.

During the observation of the lunch meal on January 4, 2016 the following was observed by the inspector:
- Residents #028, #048 and #027, were provided soup at 1205 hours. The residents did not receive assistance with their soup until 1215 hours. PSW #114 indicated that residents #028 and #048 require total assistance in feeding while resident #027 sometimes requires assistance when unable to feed self.

During the observation of the lunch meal on January 5, 2016 the following was observed by the inspector:
- Residents #028, #048 and #027, seated at table #4, were provided soup at 1212 hours. The residents did not receive assistance with their soup until 1218 hours when resident #027 was assisted with one spoon full of soup and encouraged to continue. Residents #028 and #048 received assistance with their soup at 1219 hours.
- Residents #035, #050 and #049, seated at table #7, were provided soup at 1213 hours. Residents #035, #050 and #049 did not receive assistance with their soup until 1228 hours with main course remained on table.
- Residents #029, #041 and #051, seated at table #9, were provided soup at 1213 hours. The residents did not receive assistance with their soup until 1234 hours with main course remaining untouched on table in front of residents.
- PSW started assisting resident #027 with soup at 1226 hours; Residents #028 and #048 were left without assist with main course on table in front of them.

- RPN #100 indicated to inspector #570 that she came to assist at table #9 when she noticed no one was at the table to assist residents.

On January 11, 2016 at 1215 hours Inspector #623 observed resident #029, seated at table #9, had a bowl of soup and was not eating. After five minutes a staff member came to assist the resident with the soup.

An interview with the Nutritional Care Manager was conducted on January 12, 2016 by the inspector and it was explained that the expectation at the home and as per policy is that residents should be provided with assistance once the courses are served. The Nutritional Care Manager indicated that extra staff hours are needed to assist in the dining room. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that residents who require assistance with eating will not be served a meal until someone is available to provide the assistance required by the resident and residents will receive their meals course by course unless otherwise indicated in their plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items,(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and (b) cleaned as required.

During the initial tour of the home on January 4, 2016, the following was observed:

-in the south spa room unlabelled personal care items were observed including [redacted] two shaving creams and one bar of soap in an unlabelled dish.
-in the north spa room personal care items were observed open and unlabelled including three cans
of shaving cream, [redacted]
two tubes
of toothpaste, one comb, [redacted] and two used bars of soap in an open box.

In the north and south spa rooms on January 11, 2016 @ 1400, the same items remained opened
and unlabelled as observed on January 4, 2016.

On January 13, 2016 personal care items that were unlabelled and opened were observed in the
north spa room including a urine hat on the floor, [redacted] 3 used bars of soap, a deodorant stick, a bottle of mouth rinse [redacted] one bottle of shampoo, two cans of shaving cream, [redacted]

On January 13, 2016 personal care items that were unlabelled and opened were observed in the
south spa room including one comb, one stick of deodorant, [redacted] one can of
shaving cream, [redacted] one bottle of spray deodorant

and a used uncapped personal razor.

distraction tools

On January 12, 2016 Inspector #623 interviewed PSW #112 who indicated that the [redacted] are in the basket in the North tub room to be used with the residents that are "active" in the tub so that their hands are kept busy and they don't grab at the staff. She indicated that if they [redacted] are used then they are disinfected after the bath when the tub is disinfected. If they are back in the basket then they are assumed to be clean. PSW #112 indicates the homes expectation is that all personal care items are labelled and stored in the residents room. It is the PSW's responsibility to ensure that these items are labelled and stored correctly. When asked about the unlabelled used bars of soap in the basket, the PSW indicated that all of the residents received a bar of soap for Christmas in their baskets. This PSW personally does not use them and would throw them out if found.

On January 12, 2016 Inspector #623 interviewed RN #105, RPN#100, RPN #108, all were unaware of use of distraction tools, RPN #108 indicated that if these items were used by staff to assist with managing a residents behaviour then the expectation would be that this intervention would be individualized, care planned and there would be a process in place to manage these items.

On January 13, 2016 Inspector #623 interviewed PSW #113. Inspector asked what the homes expectation is for personal care items. PSW indicated that all personal items are to be labelled and kept in the resident's bedside table. When care is to be provided the PSW is to take the items to the bathroom or the spa for the residents use and then return them to the bedside table once care is completed. It is the PSW's responsibility to ensure items are labelled and returned to the resident room.

On January 12, 2016 Inspector #623 interviewed the Admin/DOC who was unaware of any tub distraction tools, The home has not purchased these items and if they had then a process would be in place. Her expectation would be that they would be labelled and cleaned after each use. Admin/DOC also confirmed that the homes expectation is that all personal items are labelled by the PSW and stored in the residents room when not in use.

Therefore, the licensee failed to ensure that personal care items were labelled and the [redacted] distraction tools were cleaned [s. 37(1)]

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Issued on this 21st day of January, 2016

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

Patricia Mata

Original report signed by the inspector.