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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Aug 30, 2016	2016_328571_0024	013540-16	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)

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): August 24, 25, 26, 2016.

During this Resident Quality inspection, Critical Incident Log #020738-16 related to a resident missing less than three hours with no injury was also inspected.

During the course of the inspection, the inspector(s) spoke with Administrator/ Director of Care, the RAI Coordinator, Life Enrichment Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Nurses, residents and family members.

In addition, clinical health records including, care plans, assessments, physicians orders, and medication records where reviewed. Also, minutes from Resident Council meetings were reviewed.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA ,2007,S.O. 2007, c.8, s 57 (2) whereby the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Residents' Council.

Inspector #570 reviewed the Residents' Council meeting minutes for two specified months.

The meeting minutes for both specified months indicated two concerns were brought forward related to staffing and a resident's request to be seen by the doctor. The same concerns remained ongoing during the second meeting for a specified month.

Review of the licensee's response to the above concerns indicated a response 38 days after the first meeting on a specified date and a response 20 days after the second meeting on a specified date.

On August 26, 2016 the Administrator confirmed to inspector #570 that the written responses to concerns brought forward in both of these meeting minutes were not responded to within the 10 days. [s. 57. (2)]

Issued on this 30th day of August, 2016

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

Original report signed by the inspector.