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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 27, 2019	2019_591623_0008	011711-19	Complaint

Licensee/Titulaire de permis

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

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

SARAH GILLIS (623)

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 18 and 19, 2019

The following log was inspected:
Log #011711-19 complaint related to resident care

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Clinical Care Coordinator (CCC), residents and families.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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	Légende 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 resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was received via the Action Line, that indicated the following:
The complainant indicated that on a specified date, they received a call from the home indicating that resident #001 was experiencing a change in health status and they were being transferred to the hospital for assessment. The caller indicated that the hospital reported to them a specific diagnosis for resident #001. The resident was receiving treatment and had been placed in enhanced monitoring. Resident #001 passed away on a specified date in hospital. The complainant wanted to know how the home, or the doctor never realized anything was wrong.

During an interview with Inspector #623, the SDM indicated that they were first made aware of the change in condition for resident #001 on a specified date, at the time the resident was being transferred to the hospital. The SDM indicated that they had not spoken to any staff at the home for several months, when they were last visiting resident #001. The SDM indicated that they had not received notification that resident #001 had a change in condition or any new or change in medications. The SDM indicated that they typically do not receive calls from the home regarding resident #001.

A review of resident #001's physician orders and progress notes for a specific identified period of time indicated the following:
On a specified date and time, RN #111 documented that resident #001 experienced a change in condition and was to be monitored. Later that same day, RPN #112 received a physician's order to initiate resident #001 on a specified medication to treat the condition. The progress notes by RPN #112 indicated that the resident was not feeling well. There was no indication that the SDM was notified of the new medication order, or of the change in condition for resident #001. On a specified date RN #113 documented that resident #001 had a specified symptom, extra fluids were offered. On the following day, RN #103 documented that resident #001 had the same symptom and specific medication was administered. On a specified date, documentation indicated that the resident continued to experience specific identified symptoms. Four days later, documentation by RN #113 indicated that the medication was now completed, the resident was did not have any further symptoms. Throughout the seven day course of specific identified treatment, there is no documentation to support that the SDM was notified of resident #001's change in condition.

For a specific identified period of time, there were a number of documented incidents of resident #001 resisting or refusing care. There was no indication that the SDM was informed.

On a specified date and time, documentation indicated that resident #001 was discovered to be in need of medical attention. Resident #001 was symptomatic and was assessed by RN #102 then transferred to the hospital for further assessment. The SDM was notified of the transfer to hospital and the resident condition at the time of transfer.

To expand the scope, the clinical records for resident #002 and #003 were reviewed. There were no concerns identified with resident #003 related to SDM being informed when the resident experienced a change in condition or medication. Documentation supported the SDM involvement.

Resident #002 was admitted to the home on a specified date. Review of the progress notes and physician order records indicated that during a specified period of time the resident experienced six separate medication changes. There was no documented record that the SDM provided consent for the change in medication or was notified of the change in resident #002's condition:

During an interview with Inspector #623, RPN #109 indicated that when a new medication order is received, they only notify the SDM if it is a high-risk medication, not with every medication change. RPN #109 indicated that if they notified the family of a medication change, they would document this in the progress notes.

During an interview with Inspector #623, RN #113 indicated that the SDM is not always notified when a resident exhibits a change in behaviour, a new medication or a change in condition. The RN indicated sometimes the SDM is notified but it was not documented in the progress notes.

During an interview the Acting Administrator indicated that the Medical Pharmacies policy 10 - 7 Patient Counseling is to be followed. The policy indicates that the resident and/or SDM are to be notified about any new medication orders or changes in medication order, by the nurse. The physician and pharmacist may provide educational counseling upon request. The Acting Administrator also indicted that it is the expectation of the home that the SDM is made aware of any change in the resident's condition and that all attempts to contact the SDM are documented in the progress notes.

The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM was provided the opportunity to participate fully in the development and implementation of the plan of care, when the SDM for resident #001 and #002 were not informed when the resident's experienced a change in condition or a change in medications. [s. 6. (5)]

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 by ensuring that the resident, the SDM, if any, and the designate of the resident/SDM are provided the 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. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any within six weeks of the admission of the resident, and at least annually after that.

(b) the resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and
(c) a record is kept of the date, the participants, and the results of the conferences

A complaint was received via the Action Line, on a specified date and the following information was received:

The complainant indicated that on a specified date, they received a call from the home indicating that resident #001 was experiencing a change in health status and that they were being transferred to the hospital for assessment. The caller indicated that the hospital reported to them a specific diagnosis for resident #001. The resident was receiving treatment and had been placed in enhanced monitoring. Resident #001 passed away on a specified date in hospital. The complainant wanted to know how the home, or the doctor never realized anything was wrong.

During an interview with Inspector #623, the SDM indicated that they were first made aware of the change in condition for resident #001 on a specified date, when the resident was being transferred to the hospital. The SDM indicated that they had not spoken to any staff at the home since a specified date, when they were visiting resident #001. The SDM indicated that they had a meeting with the home approximately 18 months prior and they had attended two care conferences since the resident was admitted a number of years prior.

Review of the clinical records indicated that there is a written record of Care Conferences on two specified dates, both attended by the SDM. There was no additional written record of any care conferences on file for resident #001 from the date of admission.

During an interview with Inspector #623, the Acting Administrator indicated that there was a written record of two care conferences for resident #001 since admission. The Acting Administrator indicated that the expectation of the home is that a care conference would take place within six weeks of admission and annually thereafter. The Acting Administrator indicated that they were aware that these were behind and are working on a plan to catch up.

To expand the scope, two additional residents' records were reviewed, and the following was identified:

Resident #002 was admitted to the home on a specified date. Review of the progress

notes and the paper documentation records indicated that RPN #104 contacted the SDM to arrange for a care conference on a specified date ten weeks following the date of admission. A care conference took place on a specified date, eleven weeks after admission to the home.

Resident #003 was admitted to the home on a specified date. Review of the progress notes and the paper documentation records indicated that there was no record of a post admission care conference taking place. During the inspection, the Acting Administrator provided documents for resident #003 that identified the post admission care conference was held on a specified date attended by the resident's SDM, and members of the care team. The Acting Administrator indicated that the resident was admitted on a specified date and did not have a post admission care conference until seventeen weeks after the date of admission.

The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any, within six weeks of the admission of the resident, and at least annually after that. The resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and a record is kept of the date, the participants, and the results of the conferences. [s. 27. (1)]

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 by ensuring that a a care conference of the interdisciplinary team is held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any within six weeks of the admission of the resident, and at least annually after that. That the resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and a record is kept of the date, the participants, and the results of the conferences, to be implemented voluntarily.

Issued on this 27th day of June, 2019

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

Original report signed by the inspector.