Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

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Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
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Ontario

October 28, 2013

Ms. Kylie Szczebonski
Administrator
Streamway Villa
19 James Street West
Cobourg, ON K9A 2J8

Dear Ms. Szczebonski:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on September 16, 2013 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

Lyne Duchesneau for

Caroline Tompkins
LTC Home Inspector – Nursing

c. President, Resident's Council
President, Family Council

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 19, 2013	2013_195166_0032	O-000225-13	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 16, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered staff and Personal Support staff.

During the course of the inspection, the inspector(s) reviewed clinical health records and the licensee's falls prevention program.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Log O-000225-13
The licensee failed to ensure that the written plan of care for Resident #2 set out clear direction to staff and others who provide direct care to the resident.

Resident #2's plan of care related to mobility indicate:
- the resident requires extensive assistance, receives physical help with weight bearing
-locomotion on the unit, total dependence. One person assist. Full staff performance of activity during the entire shift
-locomotion off the unit, total dependence. One person assist. Full staff performance of activity during the entire shift
-transferring, total dependence. Two person assist. Full staff performance of activity during the entire shift
-walk in room, activity did not occur, further documentation in Residents #2's plan of care related to "walk" states, "Independent. No help or oversight. No set up or physical help from staff"
-walk in corridor, activity did not occur ,further documentation in Residents #2's plan of care related to "walk" states, "Independent. No help or oversight. No set up or physical help from staff". [s. 6. (1) (c)]

2. Resident #2's Resident Assessment Protocol Summary (RAPS) related to Activities of Daily Living (ADL) Functional Rehabilitation, indicates Resident #2 sustained a fractured hip. The resident is able to weight bear, no pivoting due to fracture. One staff required for transfers. The resident requires total assistance with locomotion. Resident #2's Falls RAP documents that Resident #2 has fallen in the past 30 days and also in the past 180 days. Documentation in the Falls RAP, also states."No recorded falls this quarter" [s. 6. (1) (c)]

3. Log O-000225-13
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Interventions in Resident #2's plan of care included the placing of a floor mat beside the resident's bed for the prevention of injury due to high risk for falls. On an identified date, the resident's floor mat was moved to allow the Personal Support Worker(PSW) to provide care. When the PSW left the resident's room to get supplies, the floor mat was not repositioned. The resident attempted to get out of bed, fell to the floor and

1. Log O-000225-13

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 The licensee shall ensure that the written plan of care for each resident sets out clear direction to staff and others who provide direct care to residents., to be implemented voluntarily.

Issued on this 19th day of September, 2013

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