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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 20, 2016	2016_448155_0013	027430-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

SUMMIT PLACE
850-4TH STREET EAST OWEN SOUND ON N4K 6A3

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

SHARON PERRY (155), REBECCA DEWITTE (521)

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): September 8, 12, 13, 14, 15, and 16, 2016.

The following intakes were completed within the Resident Quality Inspection (RQI):
028562-15 - 2624-000010-15 Critical Incident related to alleged staff to resident abuse;
028568-15 - 2624-000011-15 Critical Incident related to alleged staff to resident abuse;
000312-16 - 2624-000015-15 Critical Incident related to alleged unlawful conduct of a visitor that resulted in harm/risk to resident;
004733-16 - 2624-000005-16 Critical Incident related to alleged staff to resident abuse; and
019709-16 - 2624-000010-16 Critical Incident related to alleged visitor to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Environmental Services Supervisor, Maintenance/Janitor, Resident Assessment Instrument (RAI)/Staff Educator, Registered Nurse, Housekeeper, Activation Aide, Personal Support Workers, Resident Council Representative and families.

The inspectors also toured the home, observed medication administration, medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, investigation reports; posting of required information; observed provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

An interview with resident #014 on September 12, 2016, revealed the resident was upset due to the timing of care being provided by the staff.

A record review confirmed the timing of care for this resident.

An interview on September 13, 2016, with PSW #109 confirmed the timing of care for this resident.

Interviews on September 13, 2016, with the Director of Care (DOC) #111 and the Executive Director #100 confirmed the home had been providing care to some residents based on a diagnosis and it was the homes expectation that the plan of care for the resident should have been based on the residents needs and preferences for the bathing schedule. [s. 6. (2)]

Issued on this 20th day of September, 2016

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

Original report signed by the inspector.