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

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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
Mar 3, 2017	2017_599166_0005	003793-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Hope Street Terrace
20 HOPE STREET SOUTH PORT HOPE ON L1A 2M8

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

CAROLINE TOMPKINS (166), PATRICIA MATA (571)

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): February 23, 24, 27, 28, March 1, 2017

Critical Incidents, Log 030391-16, related to allegations of staff to resident verbal abuse, Log 0304171-16, related to allegations of resident to resident physical abuse and Logs 031653-16, 034907-16 related to falls were inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Resident's Council, RAI Coordinator, Dietary Aide, Housekeeping staff, Physiotherapy Assistant, Administrator, Director of Care, Registered Practical Nurses, Personal Support Workers and Registered Nurses. During the course of the inspection the inspectors toured the home, resident rooms and common areas, observed resident to resident interactions, staff to resident interactions during the provision of care, observed medication administration and infection control practices.
The inspectors also reviewed clinical documents, the licensee's investigation documentation and reviewed the licensee's policy related to zero tolerance of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Related to log 034907-16

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A Critical Incident(CIR) was submitted to the Director, reporting an injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health status.

Review of CIR documentation indicated that resident #026, when up, had a physician's order to be seated in a specific therapeutic chair in a specified position.
On the the date of the incident, staff made the decision to seat resident #026 in a regular wheelchair. Resident#026 fell from the wheelchair and sustained an injury.

Review of physician's order's indicated :
Resident #026 had a specific order related to seating and positioning.

Inspector #166, interviewed the Administrator and Director of Care(DOC).
The DOC indicated, it was a nursing decision to trial resident #026's positioning in a wheelchair. The DOC indicated there was no discussion with the physician to change the physician's order to trail the use of a regular wheelchair.

Inspector #166, interviewed the Physiotherapy Assistant (PTA).
The PTA indicated, there had been no discussion/collaboration between nursing and physio related to an assessment of trialing resident #026, in a regular wheelchair instead of positioning the resident as per the physician's order.

There is no indication that nursing staff collaborated with the physician and physiotherapy in the assessment of the resident to ensure their assessments are integrated and consistent with resident #026's plan of care. [s. 6. (4) (a)]

Issued on this 3rd day of March, 2017

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

Original report signed by the inspector.