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 # / No de registre	Type of Inspection / Genre d’inspection
Jul 13, 2018	2018_263524_0010	005397-18	Resident Quality Inspection

Licensee/Titulaire de permis

Oneida Nation of the Thames
2212 Elm Avenue R.R. #2 SOUTHWOLD ON N0L 2G0

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

Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni)

2229 Elm Avenue, R.R. #2 SOUTHWOLD ON N0L 2G0

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

INA REYNOLDS (524), ALICIA MARLATT (590), CASSANDRA ALEKSIC (689), DEBRA CHURCHER (670), DONNA TIERNEY (569), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 25, 26, 27, 28, 29, July 3, 4 and 5, 2018.

The following intakes were completed within the Resident Quality Inspection:
Log #012096-17 / Complaint #IL-51388-LO related to nursing and personal support services
Log #014288-17 / Complaint #IL-51673-LO related to falls prevention and

management
Log #017694-17 / Complaint #IL-52184-LO related to allegations of abuse
Log #024300-17 / Complaint #IL-53594-LO related to resident’s Bill of Rights
Log #026047-17 / Complaint #IL-54092-LO related to allegations of staff to resident abuse
Log #005914-18 / Complaint #IL-56171-LO related to nursing and personal support services
Log #014510-17 / Critical Incident System #3042-000007-17 related to falls prevention
Log #000864-18 / Critical Incident System #3042-000002-18 related to falls prevention
Log #015019-18 / Critical Incident System #3042-000003-18 related to falls prevention.

On-site inquiries:
Log #003050-17 / Complaint IL-49252-LO related to housekeeping
Log #015715-17 / Complaint IL-51881-LO related to nursing and personal support services
Log #017915-17 / Complaint IL-52215-LO related to allegations of staff to resident abuse
Log #018211-17 / Complaint IL-52252-LO related to laundry and medication administration
Log #018289-17 / Complaint IL-52267-LO related to nursing and personal support services
Log #011636-18 / Complaint IL-57217-LO related to skin and wound, and nursing and personal support services
Log #002436-17 / Critical Incident System #3042-000001-17 related to allegations of abuse
Log #008805-17 / Critical Incident System #3042-000006-17 related to allegations of abuse
Log #000362-18 / Critical Incident System #3042-000001-18 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Assistant Director of Care, the Dietary Services Manager, the Environmental Manager, three Registered Nurses, three Registered Practical Nurses, thirteen Personal Support Workers, two Housekeeping Aides, one Scheduler, one Coordinator, two Agency staff, the Residents’ Council

Representative, the Family Council Representative, residents and family members.

The inspector(s) also conducted a tour of the home, observed resident care provisions, resident and staff interactions, dining services, medication administration, a medication storage area, infection prevention and control practices, and the general maintenance, cleanliness and condition of the home. Inspectors reviewed residents' clinical records, postings of required information, relevant meeting minutes, complaint logs, medication incident reports, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
4 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A complaint was received by the Ministry of Health and Long-Term Care on a specific date, which included a concern related to falls interventions for an identified resident.

Progress notes in Point Click Care (PCC) were reviewed and stated that the resident was found on the floor after a fall on a specific date.

In an interview with a Registered Nurse (RN), the RN said that the resident had a history of falls. The inspector asked where staff would find information related to falls interventions and the RN stated they would use the care plan. When asked what interventions were in place related to falls prevention for the resident, the RN said there were no interventions or specific tasks in place related to falls for this resident.

In an interview with the Assistant Director of Care (ADOC) on a specific date, the inspector asked if there were standardized fall interventions for residents identified as a risk for falls. The ADOC said yes, the residents would automatically have a number of identified interventions put in place.

Review of the Falls Risk Assessment Tool (FRAT) in PCC for a specific date, showed that the resident was a falls risk.

In an interview with the ADOC, the inspector asked the ADOC if they could confirm that the resident was a falls risk. The ADOC said that based on the FRAT assessment, the resident was a falls risk resident. When asked if the ADOC would expect that standardized fall interventions for a falls risk resident be identified in their plan of care, the ADOC said yes. The ADOC said that the resident was not flagged as a risk for falls; and, was not on the falls prevention program and, falls interventions should have been identified in the care plan. When asked to confirm that the resident's care plan did not have falls interventions, the ADOC said that the resident's care plan did not have falls interventions documented.

The licensee has failed to ensure that there was a written plan of care that sets out the planned care related to falls interventions for the resident. [s. 6. (1) (a)]

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 to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

A complaint was received by the Ministry of Health and Long-Term Care on a specific date, whereby an anonymous complainant indicated that the home was using a lot of agency registered staff and questioned their qualifications.

A record review of the staff schedules from March, June and July 2018, showed that agency Registered Nurses (RN) were scheduled on the following dates:
- March 1, 4, 6, 13, 19, 20, 24, 25, 28, 29, 2018 night shifts
- March 31, 2018 day shift
- June 1, 4, 9, 10, 18, 19, 20, 21, 22, 25, 26, 27, 28, 30, 2018 night shifts.

In an interview with the Administrator/Director of Care (ADM/DOC), the ADM/DOC said that the staffing plan included only one RN to be scheduled on days, evenings and nights.

In an interview with the Assistant Director of Care (ADOC), they said that they had been using agency RN's at times to fill entire lines and that they were booked sometimes weeks in advance.

In a phone interview with the owner of an identified nursing agency on July 5, 2018, they shared that they provided RN's to the home on at least four shifts a week throughout the month of June 2018.

The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times when agency staff were pre-booked for multiple shifts in March and June 2018. [s. 8. (3)]

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 to ensure that there at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the staffing plan related to each evaluation under clause 31(3) (e) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A complaint was received by the Ministry of Health and Long-Term Care on a specific date, whereby an anonymous complainant indicated that the home was using a lot of agency registered staff and questioned their qualifications.

Another complaint was received by the Ministry of Health and Long-Term Care on a specific date, whereby an anonymous complainant indicated that a lack of staff was having an impact on resident care.

Record review of the staff schedules from March, June and July 2018 showed that agency Registered Nurses (RN) and Registered Practical Nurses (RPN) were scheduled on the following dates:
RN:
- March 1, 4, 6, 13, 19, 20, 24, 25, 28, 29, 2018 night shifts
- March 31, 2018 day shift
- June 1, 4, 9, 10, 18, 19, 20, 21, 22, 25, 26, 27, 28, 30, 2018 night shifts.

RPN:
- March 17, 18, 19, 26 and 30, 2018 day shifts
- June 2, 3, 5, 16, 17, 26 and 29, 2018 day shifts
- June 4, 5, 7, 11, 12, 13, 23 and 24, 2018 evening shifts
- June 9 and 10, 2018 evening shifts.

A record review of the staff schedules from March, June and July 2018 showed the following dates were short one of the planned PSW shifts:
- March 2, 3, 4, 14, 15, 17 and 23, 2018 night shifts
- July 2 and 3, 2018 night shifts.

The home was not able to produce or provide a written record related to each evaluation of the staffing plan that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

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 to ensure that a written record is kept related to each evaluation under clause 31(3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A complaint was received by the Ministry of Health and Long-Term Care on a specific date, which included a concern related to falls prevention and management for an identified resident.

Review of the progress notes in Point Click Care (PCC) on a specific date, stated that the resident fell and was found on the floor in their room. The resident was assisted back to their bed and left to sleep.

In an interview with a Registered Nurse (RN) on a specific date, the RN stated that

assessments were completed in Risk Management in PCC. The inspector asked what assessments were completed after a resident had fallen and the RN reviewed a document titled "Required Assessments & Interventions – Post-falls", which included the following:
"1. Head to Toe skin assessment
2. Pain (for 3 days) All three shifts
3. Falls risk Assessment (FRAT)
4. Update Care plan as necessary i.e. Fall mats in place, bed & chair alarms in place, bed to lowest position, etc.
5. Ensure Risk Management report is completed in full & signed
6. Safe Lift and Transfers (SALT)
7. Refer to PT for transfer status and mobility needs
8. Neurological vital signs record (for unwitnessed falls)".

The inspector reviewed Risk Management in PCC for the resident and accessed the "historical" tab for assessment documentation. No documentation was reported for a fall on the identified date. The inspector reviewed Risk Management in PCC for the resident and accessed "struck out" tab for struck out incidents. The falls risk incident, with the incident date and time for the resident was documented as struck out, with no details, injuries, factors, witnesses, action or notes documented.

Review of the home's policy titled "Falls Management", with a revision date of June 2009, stated the following: "Falls Assessment - The Falls Assessment is a two step process that is implemented on admission to the facility, reviewed and updated with any fall or with any change in the residents condition".

In an interview with the Assistant Director of Care (ADOC) on a specific date, the ADOC said that they would expect that the registered staff would complete all of the items listed in the "Required Assessments & Interventions - Post-Falls" document. The inspector asked the ADOC if they would expect that staff should have completed the post-falls assessment as per the falls prevention policy. The ADOC said that the post-falls assessment and risk management documentation should have, but was not completed by registered staff on the shift when the fall happened.

The licensee has failed to ensure that when the identified resident had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

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 to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

A complaint was received by the Ministry of Health and Long-Term Care on a specific date, which included a concern related to Residents' Bill of Rights for an identified resident.

In an interview with the resident, the resident stated that they were refused to exit the home into the secured courtyard area after 2200 hours. The resident stated that they had spoken with the Administrator/Director of Care (ADM/DOC) about the concern, but were told they were not allowed to leave the home after the doors were locked.

In an interview with a Personal Support Worker (PSW), the PSW said that the resident was able to make their own decisions regarding their care. When asked if the courtyard area was physically accessible for the resident, the PSW said yes. The PSW stated that the courtyard was locked in the evening around 2200 hours and that the residents were not able to go outside past this time. They said that the doors were locked because there was limited staff on nights to keep an eye on the courtyard area.

In an interview with the ADM/DOC on a specific date, the inspector said that the resident had mentioned they were not allowed to go outside in the courtyard area after 2200 hours and their concern was brought forward to the home. The ADM/DOC said that the concern was brought forward by the resident and discussed with the home. When asked if the resident was able to go into the secure courtyard area past 2200 hours, the ADM/DOC said it was not possible. The ADM/DOC said that they have limited staff available to monitor the residents during the night shift. The inspector asked if the home discussed any options or alternatives with the resident for them to be able to go outside past this time. The ADM/DOC said there were no alternatives, that there were not enough staff on the night shift to watch the residents outside and they had to maintain safety of the residents. When asked if the identified resident was safe being outside on their own, the ADM/DOC said yes.

The licensee has failed to ensure that every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity. [s. 3. (1) 26.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) The home's medication incidents for the identified quarter of January through March 2018 was reviewed for the Resident Quality Inspection.

The first medication incident reviewed documented that the resident was administered incorrect medication.

The second medication incident reviewed documented that this was an omission error, in that the medication was signed as administered, but had not been administered as the medication was found in the medication cart.

The third medication incident reviewed documented that the prescribed medication was documented as administered, but had not been administered as the medication was found in the medication cart.

In an interview with a Registered Practical Nurse (RPN), they said that when a medication error occurred the staff member was to report the error to the management team, the physician, the resident or their Power of Attorney and the pharmacist. The resident would be monitored for any adverse effects of the medication.

In an interview with the Assistant Director of Care and the Administrator/Director of Care, they both shared that these medication incidents occurred and that follow up with the involved staff had taken place. They shared that new processes had been put into place as well, to ensure that all medications were administered as ordered for the shift.

b) A complaint was received by the Ministry of Health and Long-Term Care, that a Registered Nurse (RN) who was working on a specific shift, had locked the medication keys in the medication cart. As a result, residents who were prescribed medications at a specific time were administered them late. An identified resident was specifically identified as one who had received multiple medications later than prescribed.

A progress note created by an agency registered nurse on a specific date and time, stated that the resident was administered one specific medication while waiting for management to unlock the medication room to have access to master keys to the medication cart. An additional progress note authored by a Registered Practical Nurse (RPN) on a specific date and time, indicated that the resident went out for a scheduled appointment without taking the remaining medications as the keys were locked inside the medication room. After returning from their appointment, the resident requested their medications from the previous medication pass and most were provided by the RPN.

During an interview with the Administrator/Director of Care, they said that if the progress notes written on a specific date, indicated that the resident had not received their medications until later after returning from their scheduled appointment, then it was likely true.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience. O. Reg. 79/10, s. 234 (1).
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. O. Reg. 79/10, s. 234 (1).
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act. O. Reg. 79/10, s. 234 (1).
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: 3) The results of the staff member's criminal reference check under subsection 75 (2) of the Act.

The Long-Term Care Homes Act, 2007 defines staff as, "Persons who work at the home, pursuant to a contract or agreement with the licensee."

A complaint was received by the Ministry of Health and Long-Term Care on a specific date, which included a concern related to agency staff that worked in the home having criminal reference checks.

Review of the home's staff assignment sheet for multiple days, indicated that an agency provided Registered Nurses for coverage for the day, evening and night shifts for the multiple days.

During interviews with both the Administrator/Director of Care (ADM/DOC) and the Assistant Director of Care (ADOC), they verified that the home had contracts with four different staffing agencies to provide registered staff and personal support workers as needed when the home was unable to fill shifts with their own employees. The ADM/DOC said it was the expectation of the agencies to complete criminal background checks of their staff prior to them working at the home.

When the ADM/DOC was asked if the home had records of agency staff's criminal record checks on file, or if they had requested that those staff provide verification of a completed criminal reference check, the ADM/DOC said they had not.

The licensee has failed to ensure records of criminal reference checks for agency staff were kept by the home as per legislative requirements. [s. 234. (1)]

Issued on this 25th day of July, 2018

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

Original report signed by the inspector.