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

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

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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
Nov 20, 2018	2018_778563_0020	029854-18	Critical Incident System

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

MELANIE NORTHEY (563)

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): November 15 and 16, 2018

Inspector #435 also participated in the inspection process.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Quality Care and Health Information, Registered Nurses, Personal Support Workers and residents.

The inspector also made observations of residents and care provided. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident; the goals the care was intended to achieve; and clear directions to staff and others who provided direct care to the resident.

The Critical Incident System Report documented that a written complaint letter was received from the family of a resident outlining their concerns.

The progress notes were reviewed and the resident sustained an injury and required acute care interventions.

A "Family Issue" progress note in Point Click Care (PCC) documented that new devices were in place as fall prevention strategies as part of the resident's plan of care. These strategies were communicated to the family.

The resident was observed on two occasions where they were resting in bed with a fall prevention strategy in place.

The current care plan in PCC documented under the "Falls Prevention Program" focus that the resident required staff to apply the fall prevention strategies and monitor for

safety. This intervention was documented as being put in place related to the resident's current health condition. There was no documentation related to the planned care, the goals or the directions for use related to the fall prevention strategy.

Inspector #563 showed Personal Support Worker (PSW) #104 the resident's fall prevention strategy was in place and the PSW verified that the device was an intervention to reduce falls.

The resident stated that the device was in place and was implemented not too long after the fall and decline in health.

The Manager of Quality Care and Health Information (MQCHI) #105 verified that the documentation was updated recently for the use of the device for the resident. The MQCHI #105 stated that the device was updated in the plan of care during the Minimum Data Set (MDS) Assessment quarterly review and the expectation was that the intervention for the use of a specific fall prevention strategy was to be documented as part of the care plan, kardex and Point of Care. The MQCHI #105 verified the device should have been added to the care plan by the person who assessed the resident as having needed the device and should have implemented it as part of the plan of care for fall prevention .

The licensee failed to ensure that there was a written plan of care for the resident that set out the planned care; the goals the bed sensor was intended to achieve; and clear directions to staff and others who provided direct care to the resident. [s. 6. (1)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Critical Incident System Report documented that a written complaint letter was received from the family of a resident outlining their concerns.

Initial record review of the resident’s care plan directed staff to apply the fall prevention strategies and monitor for safety.

A subsequent record review of the resident’s care plan the next day directed staff to apply the specific device and monitor for safety. The care plan was revised to include an additional fall prevention strategy.

The resident was observed on two separate occasions without the specific fall prevention strategy in place.

Personal Support Worker (PSW) #104 stated the resident did not use a specific device. PSW #104 verified that the resident's care plan stated to apply the fall prevention strategies and monitor for safety and that this was not being implemented.

The resident stated that the staff were to be putting a specific fall prevention intervention in place that day.

PSW #106 was asked if the resident used a specific fall prevention intervention and the PSW was not able to recall with certainty.

Manager of Quality Care and Health Information (MQCHI) #105 stated that the fall prevention strategies were to be in place for the resident.

The resident was observed again without the fall prevention strategy in place. MQCHI #105 verified that the specific device was not appropriately in use.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the outcomes of the care set out in the plan of care were documented.

A) The Critical Incident System Report documented that a written complaint letter was received from the family of a resident. The letter documented that the family observed the resident with a specific injury. The progress notes were reviewed related to a possible injury or a possible recent fall incident.

Initial record review of the resident's care plan directed staff to apply the fall prevention strategies and monitor for safety.

A subsequent record review of the resident's care plan the next day directed staff to apply the specific device and monitor for safety. The care plan was revised to include an additional fall prevention strategy.

The resident's progress notes were reviewed and since the initial implementation of the

specific device, there had been no further documentation related to the outcomes of the care set out in the plan of care related to the use of the device.

The resident's specific task in Point of Care (POC) was initiated, but did not document the outcomes related to the use of the device prior to the initiation date.

Administrator #101 stated that once the device was added to the care plan it would be reported to the Minimum Data Set (MDS) Coordinator for a task to be initiated in POC.

The Manager of Quality Care and Health Information (MQCHI) #105 stated the device would be documented in the care plan, progress notes, shift reports, the communication board, and it would be documented in POC tasks. MQCHI #105 also verified that a specific device was in place for the resident and stated that it was added that morning as there was no device task in place previously.

B) The Critical Incident System Report documented that a written complaint letter was received from the family of a resident. The letter documented that the family observed the resident with a possible injury. The resident's fall prevention plan of care was reviewed and there was evidence to support non-compliance related to the Long Term Care Homes Act 2007, s. 6 (9) (2). Two other residents were observed and the clinical records were reviewed.

The current care plan in Point Click Care (PCC) for another resident documented staff to apply a specific devices and monitor for safety.

The specific task list in PCC did not have a documentation requirement related to the specific devices in use for this resident.

The resident was observed in the dining room for breakfast with a specific device in place. The Registered Nurse (RN) #103 stated the device was put in place at specific times. The resident's room was also observed with a specific device in use.

The Manager of Quality Care and Health Information (MQCHI) #105 verified the specific task in Point of Care (POC) was resolved by the Assistant Director of Care (ADOC) related to the use of the devices and acknowledged it was still a part of the plan of care and required documentation in POC.

The MQCHI #105 verified that there should be a task in POC for the devices to document

the outcomes of the care provided by the Personal Support Workers (PSWs).

The licensee failed to ensure that the outcomes of the care set out in the plan of care related to the use and monitoring of the devices for the resident were documented. [s. 6. (9) 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 there is a written plan of care for each resident that set out the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and to ensure that the outcomes of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 20th day of November, 2018

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

Original report signed by the inspector.