Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 19, 2023	
Inspection Number: 2023-1470-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Oneida Nation of the Thames	
Long Term Care Home and City: Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni), Southwold	
Lead Inspector Christie Birch (740898)	**Inspector Digital Signature** Christie Birch Digitally signed by Christie Birch Date: 2023.10.19 15:27:24 -04'00'
Additional Inspector(s) Julie Lampman (522) Ina Reynolds (524)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 28, 29, and October 3, 4, 2023

The following intake(s) were inspected:

- Intake: #00096430 - Proactive Compliance Inspection (PCI)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement

Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was reviewed and revised when the resident's care needs changed.

Rationale and Summary:
During observation of a meal service, it was noted that the resident was served a specific consistency of drinks and was provided with full eating assistance and encouragement by a personal support worker to complete their meal.

Review of the resident's clinical record showed:
1. The diet order documented a different consistency of fluids, than the plan of care in Point Click Care (PCC).
2. The Minimum Data Set (MDS) significant change in status assessment documented a different direction for assistance with eating than the plan of care in PCC.
3. The nutrition screening tool documented a different nutritional risk than the plan of care on PCC.

A manager acknowledged the care plan was not revised at the time the resident's care needs had changed, and the care plan was then since updated. There was low risk to the resident at the time of the observation.

Sources: Meal observation, resident's clinical record, and interview with staff.[524]

Date Remedy Implemented: October 3, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that two resident care plans set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

Two residents identified their bathing preferences and type of assistance required, which were not documented in their care plan.

A staff member stated that they did not have a document indicating preferences for bathing. Another staff member stated they would ask another staff member what the resident's preferences were for bathing.

A manager stated that the residents did not have this bathing preference as part of their care plan and did not have a document indicating their preferences.

Sources: Review of resident's clinical record, bathing schedule, and interviews with residents and staff. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 21.

The licensee has failed to ensure that residents' care plans were based on an interdisciplinary assessment of the residents' sleep patterns and preferences.

Rationale and Summary

Two residents identified their sleep preferences which were not documented in their care plan.

A manager confirmed residents' sleep patterns and preferences were not included in residents' care plans as they were unaware that it was a legislative requirement.

Sources: Review of resident's clinical records, and interviews with residents and staff.

[522]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)

The licensee failed to ensure that the records of symptoms indicating the presence of infection in residents is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary
During a proactive compliance inspection (PCI) at the home, the Administrator/Director of Care (Adm/DOC) indicated that the Infection Prevention and Control (IPAC) lead had just started their role and prior to that it was being filled by the Adm/DOC and the ADOC.

The Adm/DOC stated that they had reviewed the infection surveillance data from PCC progress notes daily to ensure actions were taken to reduce transmission. They also stated they had not analyzed the data monthly to detect trends during the months of April, May, June, July and August of 2023.

Record review showed data collection and monthly analysis of infection surveillance was not completed for April, May, June, July or August of 2023.

There was an increased risk to residents related to infection incidence and potential outbreaks.

Sources: Interview with IPAC lead, Adm/DOC, ADOC, record review of PCC, Infection surveillance data. [740898]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that the interdisciplinary team which met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, included the Medical Director.

Rationale and Summary
The Adm/DOC stated the home's Medical Director (MD) did not attend the quarterly meetings in which

the effectiveness of the medication management system was evaluated.

The MD confirmed they did not take part in the quarterly evaluation of medication management system.
Sources: Review of the home's PAC/MAC meeting minutes, and interviews with the Adm/DOC and the MD. [522]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.

The licensee failed to ensure that the continuous quality improvement (CQI) committee membership included the home's MD.

Rationale and Summary
In an interview with the Adm/DOC and the ADOC, they stated that the CQI committee membership only included the Adm/DOC, the ADOC and a clinical lead from their management company.

A record review of the CQI meeting minutes indicated that only the Adm/DOC, ADOC and clinical lead from the management company attended the CQI meetings.

In an interview with the MD, they stated they were not on the CQI committee.

Sources: Interview with Adm/DOC, ADOC and MD, Record review of the CQI meeting minutes. [740898]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.

The licensee failed to ensure that the CQI committee membership included every designated lead of the home.

Rationale and Summary
In an interview with the Adm/DOC and the ADOC, they stated that the CQI committee membership only

included the Adm/DOC, the ADOC and a clinical lead from their management company.

A record review of the CQI meeting minutes indicated that only the Adm/DOC, ADOC and clinical lead from the management company attended the CQI meetings.

In an interview with the IPAC lead, they stated they were not on the CQI committee.

Sources: Interview with Adm/DOC, ADOC and IPAC lead, Record review of the CQI meeting minutes. [740898]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.

The licensee failed to ensure that the CQI committee membership included the home's Registered Dietician.

Rationale and Summary
In an interview with the Adm/DOC and the ADOC, they stated that the CQI committee membership only included the Adm/DOC, the ADOC and a clinical lead from their management company.

A record review of the CQI meeting minutes indicated that only the Adm/DOC, ADOC and clinical lead from the management company attended the CQI meetings.

Sources: Interview with Adm/DOC, ADOC, Record review of the CQI meeting minutes. [740898]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.

The licensee failed to ensure that the CQI committee membership included the home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

Rationale and Summary
In an interview with the Adm/DOC and the ADOC, they stated that the CQI committee membership only included the Adm/DOC, the ADOC and a clinical lead from their management company.

A record review of the CQI meeting minutes indicated that only the Adm/DOC, ADOC and clinical lead from the management company attended the CQI meetings.

Sources: Interview with Adm/DOC, ADOC, Record review of the CQI meeting minutes.
[740898]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.

The licensee failed to ensure that the CQI committee membership included at least one employee who is a member of the regular nursing staff of the home.

Rationale and Summary
In an interview with the Adm/DOC and the ADOC, they stated that the CQI committee membership only included the Adm/DOC, the ADOC and a clinical lead from their management company.

A record review of the CQI meeting minutes indicated that only the Adm/DOC, ADOC and clinical lead from the management company attended the CQI meetings.

Sources: Interview with Adm/DOC, ADOC, Record review of the CQI meeting minutes.
[740898]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

The licensee failed to ensure that the CQI committee membership included at least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home.

Rationale and Summary
In an interview with the Adm/DOC and the ADOC, they stated that the CQI committee membership only included the Adm/DOC, the ADOC and a clinical lead from their management company.

A record review of the CQI meeting minutes indicated that only the Adm/DOC, ADOC and clinical lead from the management company attended the CQI meetings.

Sources: Interview with Adm/DOC, ADOC, Record review of the CQI meeting minutes.
[740898]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

The licensee failed to ensure that the CQI committee membership included one member of the resident council.

Rationale and Summary
In an interview with the Adm/DOC and the ADOC, they stated that the CQI committee membership only included the Adm/DOC, the ADOC and a clinical lead from their management company.

A record review of the CQI meeting minutes indicated that only the Adm/DOC, ADOC and clinical lead from the management company attended the CQI meetings.

In an interview with the Resident Council President, they stated they were not a member of the CQI committee.

Sources: Interview with Adm/DOC, ADOC, Resident Council President, Record review of the CQI meeting minutes.
[740898]

WRITTEN NOTIFICATION: Medical Director

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 251 (1)

The licensee has failed to enter into a written agreement with the Medical Director (MD) for the home.

Rationale and Summary
The home's MD confirmed they did not have a written agreement with the home and the last written agreement that they had with the home had expired in 2022.

Sources:
Interview with the MD and the Adm/DOC. [522]

WRITTEN NOTIFICATION: Medical Director

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 251 (4) 5.

The licensee has failed to ensure that the MD attended and participated in interdisciplinary committees and quality improvement activities in the home.

Rationale and Summary
The MD stated they did not attend or participate in any of the home's interdisciplinary committees and quality improvement activities.

Sources:
Interview with the MD and Adm/DOC. [522]

WRITTEN NOTIFICATION: Training and Orientation Program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (2)

The licensee failed to ensure that, at least annually, the training and orientation program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary
During a PCI the Adm/DOC indicated that the Orientation and Training Program was not evaluated or updated annually, specifically it was not done in 2022.

During a record review of the required program evaluations, Orientation and Training was not completed for 2022.

Sources: Interview with Adm/DOC, record review of the program evaluations
[740898]

COMPLIANCE ORDER CO #001 Training and Orientation Program

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 257 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:
The licensee must be compliant with 0. Reg 246/22 s. 257 (1)

Specifically, the licensee shall:

1. Ensure all mandatory components of training are included in the orientation and training program.
2. Ensure all staff have completed the mandatory training as required, including documentation of the content of the training and the date the training was completed.
3. Ensure that the Orientation and Training Program is being followed, specifically, that the orientation checklist is being used as indicated in the policy and all mandatory training completed.
4. Ensure that the Orientation and Training Program is evaluated and updated, including documentation of this evaluation and update.

Grounds

The licensee failed to ensure that a training and orientation program for the home was developed and implemented to provide the training and orientation required.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), the Adm/DOC stated that they were not up to date with the mandatory annual or orientation training for staff. They also stated they did not use an orientation

checklist. The Adm/DOC and ADOC stated that all training and education was provided through an online program only for all staff annually and for orientation for new hires.

The home's policy Training and Orientation Program Policy # 01-04-01 noted " the Orientation Checklist should be used as a guide when orientating all new staff and that the items listed on the General Orientation Checklist as well as those items on their specific position checklist were to be completed. The checklist will be placed in the employee file. "

A record review of the Education Status Report for two new hires did not include all mandatory training items being completed. Specifically, one registered nurse (RN), did not complete any of the courses assigned in the online education program and another staff had completed the assigned courses in the online education program but this assignment did not include the following mandatory items:

- The Resident's Bill of Rights
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents
- The duty to make mandatory reports
- Abuse recognition and prevention
- Mental health issues, including caring for persons with dementia
- Behaviour management
- Palliative care
- Skin and wound care
- Continence care and bowel management
- Pain management, including pain recognition of specific and non-specific signs of pain

In an interview with the RN, they stated they had not completed the mandatory training upon hire or thereafter.

A record review of the Education Report for 2022 for PSWs and registered staff showed that 64 % of the staff had completed the online training assigned to them. On review of the courses assigned to staff members in the online training program it was noted that the following mandatory annual training items were not included:

- The Residents' Bill of Rights
- The long-term care home's mission statement
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents
- Abuse recognition and prevention
- Behaviour management
- Palliative care
- Falls prevention and management
- Continence care and bowel management

- Pain management, including pain recognition of specific and non-specific signs of pain

There was a significant risk to residents related to the large number of staff who had not completed the required mandatory training on orientation as well as annually.

Sources: Interview with staff, Adm/DOC, ADOC, Record review of Surge Learning Online Education program documents, Employee files, and policies.

[740898]
This order must be complied with by: January 5, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.