Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 15, 2024	
Inspection Number: 2024-1470-0002	
Inspection Type: Complaint	
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 Ali Nasser (523)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 12, 13, 2024

The following intake(s) were inspected:

- Intake: #00106973, complaint related to resident care concern.

Inspectors Stephanie Newton (000820) and Mark Smith (000815) were present during this inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services

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Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
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.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rational and Summary:
A clinical record review for a resident and staff interviews showed that multiple specific assessments completed were not consistent or complemented each other. They said it was the expectation for the staff to collaborate with each other in the assessment of the resident so that their assessments were consistent with and complemented each other.

This had minimal risk to the resident as the resident was continually assessed by

registered staff and the physician and the treatments were not impacted.

Sources: record reviews and staff interviews. [523]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (6)
Reports re critical incidents
s. 115 (6) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 246/22, s. 115 (6).

The licensee has failed to ensure that the resident's substitute decision-maker was promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be so notified.

Rational and Summary:
The Ministry of Long Term-Care received a complaint that the Power of Attorney (POA) for the resident were not informed when the resident had a change in status.

A clinical record review for the resident and staff interviews showed the resident had a change in condition on a specific date and the POA was not notified as per their documented instructions. The POA was notified at a later date.

This had minimal impact or risk to the resident.

Sources: record reviews and interviews. [523]