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 6, 2017	2017_322156_0004	027524-16, 002305-17	Complaint

Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 31, February 1, 2, 2017

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DRC), Director of Resident Quality Outcomes (DRQO), registered nursing staff, Personal Support Workers (PSWs), residents and families. During the course of the inspection the inspectors toured the home, conducted interviews, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

i) Resident #026 had a physician's order for specified monitoring by registered staff. The Treatment Administration Record (TAR) as well as the Physician's Order were inconsistent in the directions provided for staff to follow. The Director of Resident Care and The Director of Resident Quality Outcomes confirmed that the plan of care did not set out clear directions to staff and others who provide direct care to the resident in relation to taking the required monitoring.

ii) The plan of care for resident #026 indicated that the resident was to have an identified medical intervention completed over a specified amount of time, however the TARs indicated a different length of time. The Director of Resident Care and The Director of Resident Quality Outcomes confirmed on that the plan of care for this resident did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

A) The plan of care for resident #001 indicated that staff were to perform an identified medical procedure, however, the directions for the procedure were not followed. Care set out in the plan of care was not provided to the resident as specified in the plan as confirmed by staff.

B) i) Resident #026 had a physician's order to have an identified medical procedure performed in an identified length of time. A review of the resident's clinical record and interview with staff confirmed that the resident had not had the procedure performed for a three month period. It was confirmed that care was not provided as set out in the plan in the resident's plan of care.
ii) Resident #026 had a physician's order for specified monitoring by registered staff. According to the Treatment Administration Record (TAR) for the month of January 2017 as well as documentation in Point Click Care (PCC) computerized charting system under vitals, the monitoring was not completed as ordered by the physician, thereby not following the plan of care. This was confirmed by the Director of Resident Care and The Director of Resident Quality Outcomes. [s. 6. (7)]

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 the plan of care set out clear directions to staff and others who provide direct care to the resident and, to be implemented voluntarily.

WN #2: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was noted to have an order for the month of December, 2016 for an identified medication; the resident was to be monitored prior to administration of the medication and the medication held under specified circumstances. On identified dates in December, 2016, monitoring identified the medication should have been held; however, the medication was still administered. The Director of Resident Care and the Director of Resident Quality Outcomes confirmed that the medication was not administered in accordance with the directions for use specified by the prescriber for three dates in December, 2016. [s. 131. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 3rd day of April, 2017

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

Original report signed by the inspector.