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
May 11, 2017	2017_556168_0013	008289-17	Critical Incident System

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

LISA VINK (168)

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): May 3, 2017.

This Critical Incident inspection was conducted for Critical Incident number 2660-000004-17, related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), pharmacy technician, dental assistant - level II, registered dietitian (RD) and residents.

During the course of the inspection, the inspector: observed to provision of care, toured portions of the home, reviewed relevant records including but not limited to: a business file, clinical health records and a relevant policy and procedure.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services

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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

Resident #010 had a "Medical Directive" that staff may administer oxygen at three liters per minute (L/min) as needed, for up to 24 hours, if oxygen saturation was lower than 88 percent (%).
The resident had a change in condition and on an identified date in 2017, at approximately 1400 hours, the physician ordered the use of oxygen therapy at two liters per minute (L/min) to maintain oxygen saturation above 90 percent (%).
A review of the clinical record included a progress note by RPN #110, which identified that on the identified date in 2017, at approx 1151 hours, the resident received oxygen at the rate of four L/min. Interview with the RPN verified that the progress notes recorded were reflective of assessment and actions.
A progress note by RN #108, identified that on the same date, at 2206 hours, the resident received oxygen at four L/min. Interview with the RN verified that the oxygen was administered at four L/min.
The following day, at 0850 hours, a third progress note identified that the resident's oxygen was increased to four L/min by RPN #109.
Interview with the DOC verified that during a review of the clinical record it was identified that the resident received oxygen therapy at a dosage other than ordered by the physician.

Care was not provided as specified in the plan of care. [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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. A review of the clinical record, specifically Point Click Care (PCC) documentation under the "Census Record" heading, identified a time that resident #011 was on leave from the home, which was confirmed with the DOC.
A progress note, identified that the resident would be leaving the home the following day at 1300 hours.
The final progress note in the clinical record, prior to the planned date of transfer from the home identified "No behaviours noted".
The clinical record did not include progress notes to indicate that the resident had left the home, when or how they left, nor any other assessments, interventions or responses of the resident, at the time that they left the home, which was confirmed by the DOC.
B. A review of the clinical record, specifically PCC documentation under the "Census Record" heading, identified that resident #010 returned to the home, from the hospital on a specified date.
A progress note on an identified date, at 0401 hours, noted that the resident was still at the hospital, followed by a second entry at 1056 hours, which was physical assessment findings of the resident.
The record did not include a progress note related to when the resident returned to the home nor how they returned, which was confirmed during an interview with the DOC.
Interview with RPN #110, who recorded the assessment of the resident on their return from hospital identified that all assessments completed and other information documented was included in the electronic record.
Interview with the DOC identified awareness that there was no specific entry in the clinical record related to the residents return to the home and that this was discussed at the most recent Registered Nursing Staff Meeting as an expectation.

Not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 12th day of May, 2017

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

Original report signed by the inspector.