Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Jan 7, 2021	2020_583117_0020	022131-20	Complaint

Licensee/Titulaire de permis

Mohawk Council of Akwesasne
P.O. Box 579 Cornwall ON K6H 5T3

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

Tsiionkwanonhsote
70 Kawehnoke Apartments Road Akwesasne ON K6H 5R7

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

LYNE DUCHESNE (117)

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): December 8, 9,10, 11,14, 15, 16, 17, 18, 21 and 22, 2020. It is noted that a COVID-19 outbreak was declared on December 11, 2020.

This inspection relates to a complaint regarding falls, meal services, infection control and visitation guidelines..

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (acting DOC), Eastern Ontario Public Health Unit, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), Food Service Supervisor, several Dietary Aides, Activity Program staff, Administrative Support staff and to several residents.

During the course of this inspection, the inspector reviewed several resident health care records, observed provision of resident care and services, observed several meal services, reviewed visitation guidelines and reviewed the policy #4.1.12 "Falls Management Program".

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Minimizing of Restraining
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (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 has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to Personal Assistance Services Devices (PASDs).

A resident is identified as being at high risk of falls. The resident's plan of care identifies that the resident has two PASDs that are to be applied when they are up in their wheelchair.

The resident has had five (5) falls. The resident's progress notes and post-fall assessments document that the resident fell out of their wheelchair. Documentation notes that the PASDs were not applied for a fall. An RPN and a PSW report that the one PASD had not been applied for another fall. There is no information related to the status of the PASDs for the three (3) other documented falls.

As per the home's acting DOC, RPN and three (3) PSW staff members, the resident is not able to release the PASDs by themselves. By not applying the PASDs, as identified in the plan of care, the resident sustained five (5) falls and was at risk of injury.

Sources: Resident observations, Interview acting DOC, RPN and PSWs, Progress notes, Post-fall assessments and resident 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 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy and procedure put in place is (b) complied with as it relates to the Fall Prevention and Management Program for residents #001 and #011.

As per O. Reg. 79/10 s. 48 (1) every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home (1) A fall prevention and management program to reduce the incident of falls and the risk of injury.

The long-term care home's has a policy # 4.1.12 " Fall Prevention and Management Program: B: Fall and Post Fall Assessment and Management", last revised 09/15. As per the home's Falls Prevention and Management Program, registered nursing staff are" to complete a 72-hour Post Fall assessment on Point Click Care (PCC) every shift for 72 hours following the fall".

Resident #001 is identified as being at high risk of falls. The resident has had seven (7) falls. Documentation review indicates that 72-hour post fall assessments were not completed as per policy for five (5) of the reported falls.

Resident #011 is identified as being at high risk of falls. The resident has had falls on five (5) falls. Documentation review indicates that 72-hour post fall assessments were not completed as per policy for a fall.

As per the home's acting DOC, several RNs and an RPN, registered nursing staff are to follow the home's policy and ensure that residents post-fall assessments are done for a continuous 72-hour period after a fall. By not following the policy, two residents were not being consistently assessed and monitored for potential changes in health status over 72-hours post falls.

Sources: Interviews DOC, RNs and RPN, Policy #4.1.12 "Fall Prevention and Management Program", resident health care records. [s. 8. (1) (a),s. 8. (1) (b)]

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 to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure , strategy or system (b) complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of safety risks related to the use of Personal Assistance Services Device (PASD) for a resident.

A resident has a wheelchair with two types of assistive devices. The resident is identified as being at risk of falls, cognitively impaired and is unable to release the devices by themselves.

An RPN and three (3) PSWs said that the wheelchair the two types assistive devices were being applied as PASDS. In December 2020, the resident was found on the floor, beside their wheelchair, by an RPN. One wheelchair assistive device had not been applied while the other was in place. The resident was not injured.

The orders and assessments indicate that the resident is to have the wheelchair assistive devices as PASDs due to increased falls. However, the use of one type of assistive device is not specified. The acting DOC and an RPN acknowledge the safety risks associated with the use of the one type of assistive device as well as that of other assistive device and that these are not identified in the resident's plan of care. There is a potential risk of harm linked to the application of these two types of assistive devices as PASDs, specifically if not correctly applied, as evidenced by the resident's December fall.

Sources: Resident observation, staff interviews, resident medical orders, assessments and care plan [s. 26. (3) 19.]

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 must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:19. Safety Risks, to be implemented voluntarily.

Issued on this 12th day of January, 2021

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

Original report signed by the inspector.