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
Jun 16, 2016	2016_254610_0020	014115-16	Resident Quality Inspection

Licensee/Titulaire de permis

Oneida Nation of the Thames
2212 Elm Avenue R. R.#2 SOUTHWOLD ON N0L 2G0

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

Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni)

2212 Elm Avenue R. R.#2 SOUTHWOLD ON N0L 2G0

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

NATALIE MORONEY (610), DONNA TIERNEY (569), INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 17, 18, 19, 20, 24, 25, 26, 27, 31, and June 1, 2, 2016

The following, Follow up, Critical Incidents and Complaints were conducted concurrently during the Resident Quality Inspection.
This Complaint # 035538-15 was related to Admission and Discharge and was completed as an Inquiry.
This Complaint # 009962-16 was related to prevention of abuse, neglect, and retaliation.
This Complaint # 011326-16 was related to prevention of abuse, neglect, and retaliation.
This Complaint # 013055-16 was related to Sufficient Staffing.
This Critical Incident # 012318-16 was related to Falls Prevention.
This Critical Incident # 006568-16 was related too Falls Prevention.
This Critical Incident # 011184-16 was related to prevention of abuse, neglect, and retaliation.
This Follow up # 025424-15 was related to Food Production.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Quality and Health Information, the Nutrition Manager, one Cook, one Registered Dietitian, one Activity Manager, one Geriatric Liaison Nurse, one Physio Therapy Aide, one Activity Aide, seven Registered Practical Nurses, three Registered Nurses, ten Personal Support Workers, approximately 60 residents, and family members.

The inspectors completed interviews, reviewed health care records, observed resident care, reviewed relevant policies, and other reports as needed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
6 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 72. (2)	CO #001	2015_182128_0018	524

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted; every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A resident had requested assistance from staff for nourishment. The staff member refused to provide the resident with assistance.

The Administrator confirmed that residents rights should have been fully respected and promoted and that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity . [s. 3. (1) 1.]

2. The licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted; every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity

An anonymous complainant said that they had reported an incident to the home.

Record review showed that the home launched an internal investigation.

Review of the home’s policy Resident Bill of Rights section 4.1.1 revised November 2011 states: "The Resident Bill of Rights will be fully respected and promoted by all staff and associates of the home.”

In an interview with the Administrator # 100 on June 2, 2016, said that the Bill of Rights was not followed for treating the resident with courtesy and respect. [s. 3. (1) 1.]

3. The licensee failed to ensure that the following rights of residents are fully respected; that all personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On May 25, 2016, during on observation of the medication cart on Turtle Path, Inspector # 610 noted Personal Health Information (PHI) was identified on the medication packet for resident # 045 in the trash can attached to the cart.

The homes policy 4.1 Residents Rights and Safety revised November 2011:

The Resident’s Bill of Rights will be fully respected and promoted by all staff and associates of the home.

The Registered Nurse (RN) # 112 confirmed the packets with the PHI were put in the garbage without removing the information from the packets after administering the medication.

The Administrator # 100 said that it was the homes expectation that they would remove the PHI from the packets before placing the empty packages in to the garbage and had not. [s. 3. (1) 11. iv.]

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 every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity and to have her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act., to be implemented voluntarily.

WN #2: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee failed to ensure that there was a written plan of care for each resident

that sets out clear directions to staff and others who provided direct care to the resident.

Record review for resident #021 showed the resident required assistance with personal care.

Record review of the Tasks Flow Sheet on Point of Care for resident #021 was not consistent with the amount of personal care required.

Staff interview with the Director of Quality and Health Information #104 confirmed it was the home’s expectation that direction to the Personal Support Workers was provided in Point of Care. The Director of Quality and Health Information #104 further confirmed that the plan of care and Task Flow sheet in Point of Care were not consistent and did not set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. 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.

Record reviewed of resident #004's electronic Kardex and Care Plan with PSW #105, showed that resident #004's mobility assistive device was not being used as specified in the plan of care.

PSW #105 acknowledged that the care provided to resident #004 was not as specified in the plan of care. [s. 6. (7)]

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

Record review of the current plan of care on PointClickCare for resident #005 showed interventions that were in place were no longer part of the plan of care.

Interview with the Director of Quality and Health Information #104 on May 26, 2016, said that the plan of care should have been updated to reflect these changes and the home’s expectation that it should be. [s. 6. (10) (b)]

4. The licensee failed to ensure that there was a written plan of care for each resident that was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Stage one of the Resident Quality Inspection, showed that resident #008 required a treatment.

A record review of resident #008 Minimum Data Set (MDS) revealed that the same was not coded as requiring the treatment.

Policy review of the CONTINENCE CARE PROGRAM subsection 4.10.1, last reviewed November 2011, indicated that the interdisciplinary team will conduct and document a bowel and bladder continence assessment following any change in the residents condition that affects continence.

During an interview on May 26, 2016, Director of Quality and Health Information # 104 said there was no assessment completed for resident #008 that the plan of care for this resident should have been revised as the resident's care needs had changed. [s. 6. (10) (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 that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident, to ensure that the care set out in the plan of care provided to the resident as specified in the plan and to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary., to be implemented voluntarily.

WN #3: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

During a review of sufficient staffing concerns from April 1, 2016 to May 25, 2016 there were approximately 16 shifts where the homes compliment of Personal Support Workers did not met the staffing requirement for the home per internal staffing plan.

Record review for personal care in POC showed that Resident's were coded as NA by staff.

The PSW # 129 said that PSW’s are not to document NA for personal care.

The staffing plan documentation for January 5, 2016 was to be six PSW workers on the day shift. Further review of the staff assignments on May 21, and 22, 2016 showed that on May 21, 2016 on the day shift there was four PSW and five PSW on May 22, 2016.

The homes Policy Medical Records Documentation revised November 2011:

To assure that documentation is relevant to what is happening

The DQHM # 104 said that should they not have full complement of PSW’s on the floor all baths are still to be completed by the assigned PSW to those residents’ requiring bathing. DQHM# 104 also said that staff should not be using NA in POC and NA was a documentation error.

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is complied with.

Residents personal care needs were documented in the Minimum Data Set (MDS) assessment.

The homes Policy Medical Records Documentation revised November 2011:

To assure that documentation is relevant to what is happening

A review of resident # 052 plan of care did not indicate the same care that was noted in the MDS assessment.

The DQHM # 104 and the Administrator # 100 confirmed that the information in the Minimum Data Set (MDS) assessment was a coding error.

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A Residents personal care needs were documented in the Minimum Data Set (MDS) assessment.

The homes Policy Medical Records Documentation revised November 2011:

To assure that documentation is relevant to what is happening.

In an interview on May 26, 2016, the Director of Quality and Health Information #104 said that the documentation of the MDS was not accurate. [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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and was implemented in accordance with all applicable requirements under the Act, and complied with., to be implemented voluntarily.

WN #4: 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:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care included any mood and behaviour patterns, identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day and to ensure that plan of care was based on an interdisciplinary assessment that includes the resident's health conditions including allergies, pain, risk of falls and other special needs

Record review of the most recent plan of care for resident #005 and #021 revealed there was no focus statement, goals or interventions with respect to the residents' needs and safety based on the assessment.

Interview with the Director of Quality and Health Information #104 on May 26, 2016, at 0950 hours confirmed the absence of goals and interventions related to the resident's care needs were not in the plan of care and that it was the home's expectation that there should be. [s. 26. (3) 4.]

2. The licensee failed to ensure that the responsive behaviour plan of care included any mood and behaviour patterns, identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day and to ensure that plan of care was based on an interdisciplinary assessment that includes the resident's health conditions including allergies, pain, risk of falls and other special needs.

A review of resident # 052 Resident Assessment Protocol (RAP) showed that the resident had behavioural episodes

Record review of POC documentation showed that the resident behavoiurs episodes and a review of PCC showed no documentation on the behaviours.

The Administrator # 100 said that the resident with behaviours should have been in plan of care with clear directions for staff and was not. [s. 26. (3) 5.]

3. The Licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident; heath conditions, including allergies, pain, risk of falls, and other special needs.

Record review of documentation for September 9, 2015 in PCC showed resident # 052 had a health condition.

A review of the resident's health care record showed that the resident's plan of care did not include the heath condition or monitoring.

The DQHM #104 said that the resident's plan of care should have provided clear directions to staff to monitor the resident health and had not. [s. 26. (3) 10.]

4. The Licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment assessment of the following with respect to the resident; heath conditions, including allergies, pain, risk of falls, and other special needs.

A resident had a change in condition.

The homes Policy Readmission from Hospital Revised November 2011:

Readmission assessments include Head to Toe Skin Assessments and Pain Assessments.

A review of the health care records showed that the assessments were not completed.

The QDHM # 104 said that the resident should have had assessments completed. Therefore, the plan of care was not based on assessments related to the resident's status. [s. 26. (3) 10.]

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 a plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's vision, and to ensure that the responsive behaviour plan of care included any mood and behaviour patterns, identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day and to ensure that plan of care was based on an interdisciplinary assessment that includes the resident's health conditions including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the Resident Council Representative on May 26, 2016, revealed that the Resident’s Council was not consulted in developing and carrying out the satisfaction survey.

Record review of the Resident Council minutes from June 8, 2015 to May 9, 2016, revealed there was no documented evidence that the home sought any advice from the residents in developing the annual survey, sharing of the satisfaction survey outcomes or any resulting action plan.

The Administrator # 100 on May 26, 2016, revealed the Satisfaction Survey was sent out on April 1, 2016, and results will be shared at the next meeting and confirmed that the Residents' Council was not consulted in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

Interview with Administrator #100 on May 27, 2016, revealed the Family Satisfaction survey was distributed to families on April 1, 2016.

Record review of the Family Council minutes of September 28, 2015, and March 29, 2016, revealed no documented evidence to support that Council’s input was sought prior to the survey’s distribution.

Interview with the Family Council President on May 27, 2016, revealed they did not recall Council being asked to provide input/advice toward the development of the satisfaction survey prior to it’s distribution.

Interview with Administrator #100 confirmed that Family Council’s advice was not sought in the development of the survey and should have been. [s. 85. (3)]

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 licensee sought the advice of the Residents' Council and to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report for injury with respect of which a person is taken to hospital.

Record review for Resident # 056 showed the resident had a significant change in status.

The Homes Policy Critical Incidents Revised November 2011:

Significant High Risk Events that are serious to the resident include completing the MOHLTC Critical Incident Report and reporting the incident to the MOH.

The Director of Quality and Health Information (DQHM) # 104 said the home should have notified the Director within one business day of the incident with a significant change in status and did not. [s. 107. (3) 4.]

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 Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report for injury with respect of which a person is taken to hospital, to be implemented voluntarily.

Issued on this 5th day of July, 2016

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

Original report signed by the inspector.