Ontario

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

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

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Amended Public Report

Report Issue Date: November 18, 2022

Inspection Number: 2022-1470-0001

Inspection Type:
Critical Incident System

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	**Inspector Digital Signature**
Loma Puckerin (705241)	Loma S Puckerin Digitally signed by Loma S Puckerin Date: 2022.11.18 11:43:26 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 18-21 022

The following intake(s) were inspected:

- Intake: #00006363- [CI: 3042-000003-22] related to Falls Prevention

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the care set out in the resident's plan of care provided clear directions to staff and others who provided direct care to the resident related to the use of a specific treatment for that resident.

Rationale and Summary
On a specific date, the resident sustained an injury and required a specific treatment.

The resident's progress note revealed the treatment was to be used for the comfort of the resident.

A review of the resident's care plan noted the specific treatment was to be continued unless ordered by a physician. There were no further interventions related to the specific treatment.

A review of the resident's electronic medication record (eMAR) and electronic treatment administration record (eTAR) indicated no physicians' orders related to the usage or to the discontinuation of the specific treatment for the resident.

A Registered Nurse (RN) stated there were no instructions related to the specific treatment the resident.

The Director of Quality and Health Information-Nurse (DQCHI-N) stated the expectation in the home was that a specific treatment would be in the care plan, be monitored and documented on once a shift.

There was potential risk of the resident having increased discomfort due to no clear directions to staff related to the specific treatment.

Sources: Observations of resident, review of resident's clinical records and interviews with DQCHI-N and staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised when the resident's needs changed related to their fall prevention interventions.

Rationale and Summary
The resident was observed using in a specific mobility device. A review of their Kardex indicated the resident used a mobility aid.

A progress note, submitted on a specific date indicated a referral was submitted for the resident. The note stated in part that a specific clinical assessment was required for the resident.

A note on a specific date, stated to encourage the resident to use their mobility aid with one person assistance as tolerated.

The resident's care plan indicated they used a mobility aid and there was no documentation in the care plan that they used a mobility device.

Staff members interviewed all stated the resident transported using a mobility device and no longer used a mobility aid.

Observation of the resident's room, noted no fall risk or transfer status posted for resident.

Review of the resident's assessments records revealed no documentation of the requested specific clinical assessment was recorded for the resident.

The resident's care plan did not indicate fall risk and transfer status.

During observation, the RN confirmed that resident did not have a fall risk logo, or a transfer status posted in their room. The RN agreed that they should have been posted.

The QCHI-N stated transfer status should be identified in the care plan, the Kardex and the point of care and it was physiotherapy's responsibility for applying the fall risk and transfer logos in the residents' rooms.

There was potential risk that resident could have had unsafe transfers and an increased risk for falls as a result of their mobility and transfer status not being posted and revised.

Sources: Observations of resident, review of resident's clinical records and interviews with staff.

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WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC) in accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes and with the home's Hand Hygiene (HH) policy.

Rationale and Summary
On a specific date, staff members were observed transporting residents to the two of the homes dining rooms. No hand hygiene was performed on any of the residents prior to meal service.

A staff member was observed in the dining room clearing the residents' utensils and removing the residents clothing protectors after the meal service. The staff member also provided a resident with a glass of water, HH was not performed by the staff member before and after resident interactions.

Another staff member observed performing a procedure on a resident. After the procedure, the staff member removed their gloves, did not perform HH and proceeded to touch equipment.

The QCHI-N verified that staff are expected to perform HH on the residents prior to and after leaving the dining room. They also confirmed that it would be an expectation that staff should perform HH between the resident-to-resident interactions of clearing tables and removing the resident's clothing protectors.

The RN stated staff are expected to perform hand hygiene on the residents when bringing them into the dining room and it should also be performed before and after getting into the residents' space and before and after giving medications.

Sources: Observations; the home's Hand Hygiene Program document; interviews with the Director of Quality and Health Information-Nurse and other staff.

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