Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 28, 2023	
Inspection Number: 2023-1470-0003	
Inspection Type: Complaint	
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 Tatiana Pyper (733564)	**Inspector Digital Signature** Tatiana Pyper Digitally signed by Tatiana Pyper Date: 2023.06.28 15:22:23 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 13, and 14, 2023

The following intake(s) were inspected:
Intake: #00089200 - IL-13794-LO, related to care and support services.

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

Resident Care and Support Services
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 the written plan of care for a resident provided clear directions related to medical treatment to staff and others who provided direct care to that resident.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care, that included a concern related to the care and support services for a resident.

Review of the clinical records for the resident noted that the plan of care did not include clear directions related to monitoring and treatment of the resident.

A Registered Nurse (RN) stated that directions for medical therapy were not included in the resident's plan of care. The RN stated that the resident's plan of care should have included clear directions for medical therapy.

There was risk to the resident when clear directions related to medical therapy were not included in their plan of care.

Sources: review of the resident's clinical records and interview with staff members.

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WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of a resident and on the needs and preferences of the resident.

Rationale and Summary

During the inspection, a resident was observed to have an assisted device.

Review of the resident's clinical records indicated that they had an assessment completed, which specified that they did not require an assisted device. Review of the resident's plan of care indicated that the use of an assisted device was not included in their plan of care.

Administrator/Director of Care (DOC) stated that the care plan for the resident did not include the use of an assisted device.

There was potential risk to the resident when an assisted device was used, even though their clinical assessment indicated that an assisted device was not recommended.

Sources: review of the resident's clinical records and interview with Administrator/DOC.

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