Ontario

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 # / No de registre	Type of Inspection / Genre d'inspection
Apr 17, 2018	2018_546585_0009	004892-18	Resident Quality Inspection

Licensee/Titulaire de permis

Six Nations of the Grand River
1745 Chiefswood Road P.O. Box 5000 Ohsweken ON N0A 1M0

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

Iroquois Lodge Nursing Home
1755 Chiefswood Road P.O. Box 309 Ohsweken ON N0A 1M0

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

LEAH CURLE (585), LESLEY EDWARDS (506), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 8, 9, 12, 13, 14 and 15, 2018.

The following Critical Incident System (CIS) inquiries were completed concurrent to this Resident Quality Inspection (RQI):
Log #005337-18, CIS #2724-000005-18 and log #005338-18, CIS #2724-000006-18, both related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, families, visitors, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), housekeeping staff, the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Co-ordinator, Registered Dietitian, Food Services Manager, Environmental Manager, Programs Manager, former Staff Educator, current Staff Educator and the Administrator-Director of Care (DOC).

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, investigative notes, training information and clinical health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
3 VPC(s)
2 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A) Resident #002's clinical record was reviewed and identified they were at risk for falls. On an identified date in February 2018, the resident experienced two falls, one of which resulted in injury. RPN #115 was interviewed and reported the home's expectation was for staff to complete a 72 hour Post Fall progress note (PN) after any fall and confirmed post-fall assessments were not completed for both falls.

The Administrator-Director of Care (DOC) was interviewed and confirmed no post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls when resident #002 experienced two falls on an identified date in February 2018.

B) Resident #007's clinical record was reviewed and identified they were at risk for falls. Review of progress notes identified that they experienced eight falls during a specified period in 2018; however, no post-fall assessment was completed on six occasions when they experienced unwitnessed falls, including one fall that resulted in injury.

The Administrator-DOC was interviewed and confirmed the home's post-fall assessment instrument was the 72 hour Post Fall PN and staff were expected to complete the assessment after each fall. The Administrator-DOC confirmed no post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls when the resident experienced six falls during a specified period in 2018.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

A) A Bed Entrapment Assessment was conducted on admission for resident #005 and stated bed rail(s) were used. Review of the written plan of care, which included the care plan, directed staff not to use bed rail(s). On identified dates in March 2018, the resident was observed in bed with bed rail(s) raised. RPN #104 and Personal Support Worker (PSW) #105 were interviewed and confirmed the resident used bed rail(s). Registered Nurse (RN) #103 was interviewed and confirmed bed rail(s) were raised while the resident was in bed and that resident's written plan of care did not provide clear direction to staff and others who provided direct care to the resident regarding the use of bed rails.

B) Resident #003’s written plan of care was reviewed. Under the mobility section, the written plan of care stated they did not use bed rail(s); however, under the falls section, the plan stated they used rail(s). On a specified date in March 2018, the resident was observed in bed with a bed rail(s) raised. PSW #112 was interviewed and confirmed the resident used bed rail(s). The Administrator-DOC was interviewed and confirmed the written plan of care did not provide clear directions to staff and others who provided direct care to the resident in relation to the use of bed rails.

C) Resident #007's clinical record was reviewed and indicated they were at risk for falls and had experienced multiple falls in 2018. Review of their resident care information card posted in their closet, which was part of their written plan of care, stated they used a specified fall intervention; however, their care plan, which was also part of the written plan of care, did not include the specified fall intervention. The care plan also indicated the level of assistance they required for transfers; however, their resident care information card did not specify what level of assistance they required with transfers. PSW #108 was interviewed and reported the resident used the specified fall intervention. The Administrator-DOC was interviewed and reported the resident care card and care plan were both part of the written plan of care; however, confirmed the documents did not provide clear direction regarding the use of the specified fall intervention and the level of assistance required for transfers. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #011's December 2017 Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment was reviewed and indicated they had worsening intensity or frequency of pain. This was confirmed with registered staff #110 and PSW #111 who reported the resident expressed pain and received a specified intervention for pain. The resident's plan of care was reviewed and did not include a focus related to pain. The RAI-MDS Coordinator reviewed the resident's record and confirmed the accuracy of the assessment and that the plan of care did not include a focus related to pain. The home did not ensure that the plan of care for resident #011 was based on an assessment of the their needs and preferences related to pain. [s. 6. (2)]

3. 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.

The home's Medication Incident Report Form from an identified date in February 2018

was reviewed and noted resident #021's physician's order indicated they were to receive a specified nutrition intervention. According to the report, the resident did not receive the nutrition intervention as directed by the physician. 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. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

Resident #007's clinical record was reviewed and identified they were at risk for falls. Their plan of care regarding falls included a goal for no falls. Specified interventions were documented in the plan of care on an identified date in 2018.

The resident's fall history reviewed and identified they experienced multiple falls during a specified period in 2018 over the course of approximately six weeks. For one of the fall incidents, the resident sustained injuries as a result of the fall. No changes made to the plan of care in relation to falls when the resident continued to experience falls.

The Administrator-DOC was interviewed and confirmed the resident was at risk for falls and experienced multiple falls during the specified period in 2018. The Administrator-DOC confirmed that no actions were taken to prevent recurrence of multiple falls that occurred between a specified period in 2018. The licensee failed to ensure resident #007 was reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 and ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and 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 #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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg 79/10, s. 30. (1) 1., there must be written description of the falls program required under s. 49. (1) that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcome, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the licensee’s policy, "Falls Assessment, Prevention and Management", last reviewed March 2016, which was part of the licensee’s falls prevention and management program. The policy directed staff to regard all unwitnessed falls as potential head injuries and commence the Head Injury Routine (HIR). The HIR form, titled Neurological Flow Sheet, directed staff to assess the resident at the time of the incident, every 30 minutes for two hours, every hour for 6 hours, every four hours for 16 hours for a total of 24 hours of monitoring.

A) Resident #002's clinical record was reviewed and identified they were at risk for falls. On an identified date in February 2018, they experienced an unwitnessed fall that resulted in injury. No HIR was located in their clinical record. RPN #104 was interviewed and reported the home's expectation was for staff to complete the Neurological Flow Sheet for all unwitnessed falls and confirmed HIR was not completed as required.

The Administrator-DOC was interviewed and reported the home's policy regarding falls prevention and management directed staff to complete HIR for all unwitnessed falls and stated staff did not comply with the home's policy when resident #002 experienced an unwitnessed fall that resulted in injury.

B) Resident #007's clinical record was reviewed and identified they were at risk for falls. Over a period of approximately six weeks in 2018, the resident experienced multiple unwitnessed falls. For each fall incident, HIR was initiated; however, the Neurological Flow Sheet Forms were not fully completed as required as per the assessment schedule for multiple fall incidents. The Administrator-DOC was interviewed and confirmed staff did not comply with the home's policy to complete HIR for multiple unwitnessed falls between during an identified period in 2018. [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 and ensure that 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 plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations and 6. Any other areas provided for in the regulations.

A) The licensee failed to ensure that direct care staff were provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining as set out in the Act and Regulations annually.

The home was requested to provide documentation regarding their annual education on physical devices and/or restraint education provided to all direct care staff in 2017; however, no records were provided. The home's 2017 Staff Educator confirmed that the annual restraint education was not provided to direct care staff in 2017.

B) The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1), in the area(s) of: 1. Falls prevention and management.

The home's 2017 staff education records were reviewed and identified 54 per cent (%) of direct care staff did not receive training in the area of falls prevention and management. The Administrator-DOC was interviewed and confirmed not all direct care staff received training in the area of falls prevention and management in 2017. [s. 76. (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 and ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During the course of the inspection, resident #006's bed was observed with bed rail(s) engaged. Their plan of care indicated they required the use of the bed rail(s) for safety; however, no Bed Entrapment Assessment was found to verify that they had been assessed and that their bed system had been evaluated to minimize risk to the resident. RN #103 confirmed resident #006 used the bed rail(s) for safety and a Bed Entrapment Assessment was not completed for resident #006 as required by the home. The home failed to ensure that resident #006 was assessed to minimize risk to the resident in relation to the use of bed rails. [s. 15. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Review of the home's written record of their 2017 falls prevention and management program evaluation did not include the dates the changes were implemented, which was confirmed in an interview with the Administrator-DOC. [s. 30. (1) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

The home's 2017 Professional Advisory Committee (PAC) meeting record was reviewed and it did not include an evaluation of the licensee's policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements were required to prevent occurrences. The Administrator-DOC confirmed the evaluation was not completed as it was missed from the agenda. The 2017 abuse prevention program was not evaluated. [s. 99. (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that once in every calendar year, the home conducted an evaluation to determine the effectiveness of the licensee's policy under section 29 of the Act, and identified what changes and improvements were required to minimize restraining and ensure that restraining was done in accordance with the Act and Regulation.

The home's annual evaluation of the minimizing of restraining program was requested. The home provided a record of the 2017 evaluation of programs completed during the PAC meeting held January 24, 2018. The information did not include information related to the evaluation of the 2017 physical devices and minimizing of restraining program. The Administrator-DOC confirmed that this information was missed during the PAC meeting. The physical devices program was not evaluated in 2017. [s. 113. (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The home's Medication Incident Report was reviewed and noted that on a specified date in January 2018, the physician order indicated that resident #006 was to receive a medication at a specified dose. As per the report, the staff gave the resident the wrong dose, noted to be in the medication pouch provided by the pharmacy. The physician and resident were informed and the physician changed the order. It was noted that there was no harm to the resident. The home did not administer the medication to resident #006 in accordance to the directions for use specified by the prescriber.

B) The home's Medication Incident Report was reviewed and noted that on a specified date in 2017, resident #020 returned from the hospital and the physician order indicated they were to restart a specified medication. The order was not taken off hold and was missed during the November 2017 quarterly medication review. The omission was discovered on the second check of February 2018 quarterly medication review. There was no harm to the resident noted. The physician and resident were notified. The home did not administer the medication to resident #020 in accordance to the directions for use specified by the prescriber.

C) The home's Medication Incident Report was reviewed and noted the physician cancelled resident #022's regularly scheduled medication and the new order indicated the resident was to receive a specified medication as needed (PRN) only. On a specified date in February 2018, the staff gave the regularly scheduled dose to the resident. It was noted that there was no harm to the resident. The home did not administer the medication to resident #022 in accordance to the directions for use specified by the prescriber between specified dates in August to February 2018. [s. 131. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was: reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's Medication Incident Report was reviewed and noted the physician cancelled resident #022's regularly scheduled order of a specified medication to an as needed dose only. On a specified date in February 2018, the staff gave a scheduled dose of the medication to the resident. It was noted that there was no harm to the resident. It was noted that the physician, the resident and the SDM were not notified of the medication incident involving resident #022; which was confirmed in an interview with the Administrator-DOC. [s. 135. (1)]

Ontario

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

Issued on this 19th day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), LESLEY EDWARDS (506), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2018_546585_0009
Log No. / No de registre :	004892-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 17, 2018
Licensee / Titulaire de permis :	Six Nations of the Grand River 1745 Chiefswood Road, P.O. Box 5000, Ohsweken, ON, N0A-1M0
LTC Home / Foyer de SLD :	Iroquois Lodge Nursing Home 1755 Chiefswood Road, P.O. Box 309, Ohsweken, ON, N0A-1M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Davis Hill

To Six Nations of the Grand River, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 49. (2)

Specifically, the licensee shall ensure that:

a) When resident #002 and #007, and any other resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for fall.
b) All registered staff are aware and trained on the process of when and how to complete a post-fall assessment. This retraining should be documented.
c) An auditing system is developed and implemented to ensure that all post-fall assessments are completed as required. The auditing system should be documented and a record maintained, including any corrective action(s) taken.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A) Resident #002's clinical record was reviewed and identified they were at risk for falls. On an identified date in February 2018, the resident experienced two falls, one of which resulted in injury. RPN #115 was interviewed and reported the home's expectation was for staff to complete a 72 hour Post Fall progress note (PN) after any fall and confirmed post-fall assessments were not completed

for both falls.

The Administrator-Director of Care (DOC) was interviewed and confirmed no post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls when resident #002 experienced two falls on an identified date in February 2018.

B) Resident #007's clinical record was reviewed and identified they were at risk for falls. Review of progress notes identified that they experienced eight falls during a specified period in 2018; however, no post-fall assessment was completed on six occasions when they experienced unwitnessed falls, including one fall that resulted in injury.

The Administrator-DOC was interviewed and confirmed the home's post-fall assessment instrument was the 72 hour Post Fall PN and staff were expected to complete the assessment after each fall. The Administrator-DOC confirmed no post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls when the resident experienced six falls during a specified period in 2018.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 3 history as they had on-going non-compliance with this section of O. Reg. 79/10 that included:
• a voluntary plan of correction (VPC) issued June 13, 2017 (2017_558123_0003). (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2018

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s.6 (10) of the LTCHA.

Specifically, the licensee shall ensure that resident #007, and any other resident is reassessed and their plan of care reviewed and revised when care set out in the plan has not been effective in relation to fall prevention and management, as well as related care areas including but not limited to: transfers, mobility and safety.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

Resident #007's clinical record was reviewed and identified they were at risk for falls. Their plan of care regarding falls included a goal for no falls. Specified interventions were documented in the plan of care on an identified date in 2018.

The resident's fall history reviewed and identified they experienced multiple falls during a specified period in 2018 over the course of approximately six weeks. For one of the fall incidents, the resident sustained injuries as a result of the fall. No changes made to the plan of care in relation to falls when the resident continued to experience falls.

The Administrator-DOC was interviewed and confirmed the resident was at risk for falls and experienced multiple falls during the specified period in 2018. The Administrator-DOC confirmed that no actions were taken to prevent recurrence of multiple falls that occurred between a specified period in 2018. The licensee failed to ensure resident #007 was reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• voluntary plan of correction (VPC) issued April 24, 2015 (2015_240506_0008);
• voluntary plan of correction (VPC) issued June 23, 2016 (2016_267528_0010);
• voluntary plan of correction (VPC) issued June 13, 2017 (2017_558123_0003).
(585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 11, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Leah Curle

Service Area Office / Bureau régional de services : Hamilton Service Area Office