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 prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
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Telephone: (905) 546-8294
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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 11, 2019	2019_689586_0001	008053-18, 008342-18, 012770-18, 033276-18	Critical Incident System

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

JESSICA PALADINO (586), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 3, 4, 7, 9 and 10, 2019.

The following Follow-Up Inspections were completed:
008053-18 - Falls Prevention and Management; and,
008342-18 - Plan of Care.

The following Critical Incident System (CIS) Inspections were completed:
012770-18 - Falls Prevention and Management; and,
033276-18 - Prevention of Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Occupational Therapist (OT), Physiotherapist (PT), Physiotherapy Assistant (PTA), Staff Educator, Resident Assessment Instrument (RAI) Co-ordinator, Employee Relations Officer and Administrator/Director of Care (DOC).

During the course of the inspection, the inspector(s) reviewed clinical records, internal human resource files, internal investigation notes, policies and procedures, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
0 VPC(s)
2 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2018_546585_0009	169

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 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 has failed to ensure that when resident #002 had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of resident #002's falls history revealed the resident had several falls and was identified at a particular fall's risk. On a number of identified occasions in 2018 the resident fell and a post-fall assessment was not completed. This was confirmed during an interview with the RAI-MDS coordinator during the inspection.

The home's policy, "Falls Prevention Management Program" (4.1.12, last revised June 2009) directed the staff to complete a post-fall assessment for all falls that occur in the home.

The licensee failed to ensure that when a resident has fallen, they were assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was protected from physical abuse.

O. Reg. 79/10, s. 2 (1) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident", and defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

A CIS was submitted to the Director on an identified date in 2018 which described an incident between resident #001 and staff #105.

According to the home's internal investigation notes, staff members #104 and #105 were providing care to resident #001 when staff #105 and the resident became involved in an interaction. This was witnessed by staff #104 who was also in the room.

Resident #001 was non-interviewable.

The Police were contacted as a result of the incident. Staff #105 was not available for interview during the inspection.

Staff #104 was interviewed and confirmed the incident. According to the Administrator/DOC, staff #103 and staff #104, resident #001 was not protected from abuse by staff #105. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy promote zero tolerance of abuse and neglect of residents was complied with, according to s. 20 (2) (d).

The licensee's policy, 'Residents Rights and Safety, 4.1.2 Abuse Prevention', indicated that anyone who had reasonable grounds to suspect that abuse of a resident by anyone occurred shall immediately report the suspicion and the information upon which it was based to their Supervisor, the Manager and Director of Health Services.

On an identified date in 2018, staff #104 witnessed an interaction between resident #001 and staff #104. The staff member did not report the incident to the nursing staff until several hours later.

In an interview with staff #104 they confirmed that they did not immediately report the incident and indicated they should have. This was also confirmed through the home's internal investigation notes and interview with the Administrator/DOC. The licensee's abuse policy was not complied with. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken with respect to resident #002 were documented and response to the interventions were documented.

A CIS was submitted an identified date in 2018 that identified there was an incident that caused an injury to resident #002, for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The incident resulted in an injury to the resident.

The licensee implemented specific interventions to mitigate and manage the resident's fall risk, and this included interventions put into place by the OT. A review of the clinical record indicated there was no documentation t identify a referral to the OT was completed, what the assessment identified, and the recommendations made by the OT.

Interview with the OT during the inspection it was confirmed they did not leave any documentation in the clinical record as they did not have access to the electronic documentation system. During the interview, the OT did provide documentation to the inspector of the referral, assessment, reassessment, interventions and the residents responses to the interventions; however, the documentation were private notes and not included in resident #002's clinical record.

Interview with the Administrator confirmed the OT did not have access to the home's electronic documentation system, therefore there was no clinical documentation of the OT's consultation.

The licensee failed to ensure that the assessment, reassessment, interventions and the resident's responses to the interventions were documented for resident #002. [s. 30. (2)]

Issued on this 11th day of January, 2019

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

Original report signed by the inspector.

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) :	JESSICA PALADINO (586), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2019_689586_0001
Log No. / No de registre :	008053-18, 008342-18, 012770-18, 033276-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 11, 2019
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 :	Hanna Lammel-Joseph

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_546585_0009, CO #001;

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 any 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.

b) The licensee’s policy, Falls Prevention and Management Program" (4.1.12, last reviewed February 2011) is reviewed and revised where necessary to provide clear direction to staff related to the actions taken when a resident has fallen, specifically in relation to the expectation for completion of post-fall assessments. The revised policy shall be complied with.

c) 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 and a record maintained.

d) 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. 1. The licensee has failed to ensure that when resident #002 had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of resident #002's falls history revealed the resident had several falls and was identified at a particular fall's risk. On a number of identified occasions in 2018 the resident fell and a post-fall assessment was not completed. This was confirmed during an interview with the RAI-MDS coordinator during the inspection.

The home's policy, "Falls Prevention Management Program" (4.1.12, last revised June 2009) directed the staff to complete a post-fall assessment for all falls that occur in the home.

The licensee failed to ensure that when a resident has fallen, they were assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The severity of the issue was determined to be a level 2 as there was potential for actual harm to residents in the home. The scope of the issue was a level 1 as it was an isolated incident. The home had a level 4 history as they had ongoing noncompliance of the same legislative reference as follows:
-Voluntary Plan of Correction (VPC) issued on June 13, 2017, 2017_558123_0003; and,
-Compliance Order (CO) issued on April 17, 2018, 2018_546585_0009, due date of July 6, 2018. (169)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 12, 2019

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that resident #001 was protected from physical and verbal abuse by staff in the home. The licensee shall also re-train all front-line staff on the requirement to immediately report any alleged, suspected or witnessed incident of abuse. This retraining should be documented and a record maintained.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that every resident was protected from physical abuse.

O. Reg. 79/10, s. 2 (1) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident", and defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

A CIS was submitted to the Director on an identified date in 2018 which described an incident between resident #001 and staff #105.

According to the home's internal investigation notes, staff members #104 and #105 were providing care to resident #001 when staff #105 and the resident became involved in an interaction. This was witnessed by staff #104 who was also in the room.

Resident #001 was non-interviewable.

The Police were contacted as a result of the incident. Staff #105 was not available for interview during the inspection.

Staff #104 was interviewed and confirmed the incident. According to the Administrator/DOC, staff #103 and staff #104, resident #001 was not protected from abuse by staff #105.

The severity of the issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it was an isolated incident. The home had a level 2 history as they had unrelated noncompliance. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 12, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 11th day of January, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Jessica Paladino

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