Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Feb 21, 2020	2020_624196_0005	020232-19, 020922-19, 022436-19, 000413-20	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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), MELISSA HAMILTON (693)

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): February 11 - 13, and 19, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
- One intake for an incident of alleged staff to resident abuse;
- One intake for improper/incompetent care of a resident;
- One intake for an incident of resident elopement; and
- One intake regarding a fire.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the previous DOC, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Food Service Supervisor (FSS), Extendicare Assist Long-Term Care Nurse Consultant, Extendicare Assist Regional Director, Personal Support Workers (PSWs), and residents.

The Inspectors also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff-to-resident interactions, and interactions between and among residents, reviewed relevant resident health care records, internal investigation files, employee files, as well as relevant licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
4 VPC(s)
0 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	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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, within 24 hours of the resident’s admission.

A Critical Incident System (CIS) report was submitted to the Director for an incident of improper/incompetent treatment of resident #003 that resulted in a risk of harm. The report outlined that resident #003 was admitted to the home on a specific date and was observed to have a concern as noted by the Environmental Services Supervisor five days later. The report further indicated the admission process for this resident had not been completed in entirety.

A review of the home's policy titled, "Admission Procedure - 4.2.2 Admission Process" last reviewed "3/11", was conducted. The policy indicated:
- "While completing the admission assessment the nurse will complete a held to toe assessment and observe for any open areas, questionable bruises or abrasions. These must be recorded on the admission notes".

The health care records for resident #003 were reviewed by Inspector #196. The progress notes recorded on the date of admission to the home included a specific medical condition. A progress note dated five days later, outlined the discovery and assessment of the specific medical condition, notification of the physician, and that the head to toe skin assessment had not been completed on admission.

During an interview, Extendicare Assist Long-Term Care Nurse Consultant #105 reported to the inspector that this resident should have had a head to toe physical assessment upon admission to the home.

During an interview, previous DOC #106, reported that the nursing staff should have conducted a physical assessment, head to toe assessment, and the nursing staff didn't do this. They further added that despite being a particular type of admission, the nursing staff should have followed the home's admission procedure and completed a head to toe assessment. [s. 50. (2) (a) (i)]

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 that ensures a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, within 24 hours of the resident's admission, to be implemented voluntarily.

WN #2: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below: The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents.

A Critical Incident System (CIS) report was submitted to the Director on a specific date at a specific time for an incident of improper/incompetent treatment of a resident that resulted in harm or risk to a resident. Prior to the submission of the report, an after hours phone call was made to inform the Director. The report outlined the details of the incident involving resident #002. The report was amended four days later and indicated that someone other than the management of the home had notified the police the day after the incident.

During an interview, the previous DOC #106 reported they had not had any training on the home's policy on zero tolerance of abuse and neglect of residents; and they had not reported the incident of alleged abuse to the police as they didn't know it was supposed to be reported.

During an interview, the Administrator reported to the inspector that they started at the home in August 2019; they had not had specific training on the home's policy on zero tolerance of abuse and neglect of residents; that at the time they didn’t think the incident needed to be reported to the police but confirmed that the police should have been notified at the time the CIS report was submitted to the Ministry. [s. 76. (2) 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 that ensures no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below: The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

A Critical Incident System (CIS) report was submitted to the Director on a specific date at a specific time for an incident of improper/incompetent treatment of a resident that resulted in harm or risk to a resident. Please see WN #2 for details of the report.

The home's policy titled, "Abuse and Neglect Prevention Program - 4.1.2 Abuse prevention" last revised "12/10", indicated that, "The Manager/Designate shall notify the police immediately incident that the home suspects may constitute a criminal offense, including physical abuse, sexual abuse or financial abuse. "

The Inspector reviewed the home's investigation file. An interview with resident #002 as recorded by the DOC, indicated the details of the incident. Further interview notes identified the notification of the POA; the physician; medical director of the Lodge; after hours call to the ministry and the submission of the CIS report. Notes recorded on the following day, outlined concerns from a person and the request for a police investigation.

During an interview, Extendicare Assist Long-Term Care Nurse Consultant #105 reported to the inspector that the incident should have been reported to the police; that it was in the policy.

During an interview, previous DOC #106 reported that they had not reported the incident to the police as they didn't know it was supposed to be reported.

In an interview, the Administrator reported that at the time they didn’t think the incident needed to be reported to the police, but confirmed that the police should have been notified at the time the CIS report was submitted to the Ministry. [s. 98.]

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 that ensures the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #4: 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 has failed to ensure that at least once in every calendar year, an evaluation was 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 were required to prevent further occurrences.

The home's policy titled, "Abuse and Neglect Prevention Program - 4.1.2 Abuse prevention" last revised "12/10", was reviewed by the inspector.

In an interview, DOC #101 reported that the home was currently using the Extendicare policies on abuse, but at the time of the incident they were using the older policy which was last revised in 2010.

During an interview, Extendicare Assist Long-Term Care Nurse Consultant #105 confirmed that the policy was last revised on "12/10", and had not been reviewed and revised to reflect the current legislation and the Extendicare policies would soon be implemented.

During an interview, Extendicare Assist Regional Director reported the home would be implementing the Extendicare policies and had started training the Administrator and the DOC with these policies on reporting and abuse. [s. 99. (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 that ensures 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, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 1. An emergency, including fire, unplanned evacuation or intake of evacuees.

A Critical Incident System (CIS) report, was submitted to the Director on a specific date and time, for a fire that occurred in the home on the previous date. The CIS report indicated that there was a fire, in a particular area and the fire was contained. The report further identified that no residents were affected by the fire, and there was no need for evacuation.

During an interview with the Food Service Supervisor (FSS), they identified that the fire started on a specific date and time and after they attempted to put out the fire with a fire extinguisher, the Charge RN called 911 and informed the Administrator.

Inspector #693 reviewed the home's policy, titled, "Critical Incident Reporting (ON), RC-09-01-06", last updated in June, 2019. The policy indicated that the home was to report and submit all Mandatory and Critical Incidents to the Ministry of Health and Long Term Care, within the required timeframes, in accordance to the Ontario Long Term Care Homes Act, 2007, as well to ensure the Director was informed immediately, in as much detail as possible in the event of an emergency, including fire, unplanned evacuation or intake of evacuees.

During an interview with the DOC, they stated the CIS report was submitted to the Director, on a specific date, one day after the fire occurred, and it should have been submitted immediately, or the Ministry of Long-Term Care after hours pager should have been contacted, at the time of the fire. [s. 107. (1) 1.]

Issued on this 21st day of February, 2020

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

Original report signed by the inspector.