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
Jul 15, 2021	2021_704682_0011	008934-21	Complaint

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

AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 28, 29, 30, July 2, 12, 13, 2021.

The following Complaint inspection was completed:
008934-21 related to medication administration.

This Complaint inspection was done concurrently with Critical Incident System inspection 2021_866585_0008.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Ohsweken and Brant County public health staff, families and residents.

During the course of this inspection, the inspector observed the provision of the care, Infection Prevention and Control (IPAC) practices and reviewed clinical health records, medication incidents reports and analysis forms, staffing schedules, meeting minutes, policy and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A review of the Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, directed all staff to wear appropriate eye protection when within two metres of a resident (s) as part of provision of direct care and/or when interacting with a resident in an indoor area.

Observations of the home identified that eye protection was not worn by staff in accordance with the most current and applicable direction to the long term care home. Observations of a home area and hallway within the home, identified personal support worker's (PSW's) had assisted multiple resident's without wearing any eye protection. These staff were observed to be less than two metres of residents in an indoor space.

A Registered Practical Nurse (RPN) stated they were not aware of the requirement to wear eye protection when providing care within two metres of residents. The Assistant Director of Care (ADOC) confirmed that staff were not wearing eye protection when within two metres of residents indoors. Consultation with the Ohsweken public health office and Brant County Public Health unit confirmed that all staff should be wearing eye protection at all times within two metres of residents while indoors. Failure to follow the additional precautions/practices of staff wearing eye protection put all residents residing in the home at increased risk of potential exposure to COVID-19.

The home was not a safe and secure environment for its residents when staff did not follow the infection prevention and control (IPAC) measures set out in Directive #3 implemented to protect residents in long term care homes from COVID-19.

Sources: Observations of home area, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Interviews with Ohsweken public health nurse, Brant County Public Health Nurse and other staff. [s. 5.]

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 to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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 a resident in accordance with the directions for use as specified by the prescriber.

A complaint alleged that a resident was involved in medication errors. The home's "Administrating Routine Medications" policy directed registered staff to inspect and verify for correctness against the resident's medication administration record (MAR) sheet verifying competence, safety and authority.

A) According to the home's medication incident documentation system and a resident's clinical record, a Registered Nurse (RN) administered medications at an identified time. The RN confirmed they had administered medication at the wrong time and made a medication error.

B) According to the home's medication incident documentation system and a resident's clinical record, A RPN administered medications on an identified date. The RPN confirmed that they had made in error in the dose of medication prescribed.

The resident was at risk for an adverse event when they were administered drugs that were not in accordance with the directions for use as specified by the prescriber.

Sources: Resident's electronic medical record, medication incident report and analysis forms, Administering Routine Medications policy, Interviews with RN, RPN and other staff. [s. 131. (2)]

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 to ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

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Issued on this 16th day of July, 2021

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

Original report signed by the inspector.