Ontario

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

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: February 27, 2023

Inspection Number: 2023-1220-0001

Inspection Type:
Critical Incident System

Licensee: Six Nations of the Grand River

Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken

Lead Inspector	**Inspector Digital Signature**
Adiilah Heenaye (740741)	Adiilah H Heenaye Sumser Digitally signed by Adiilah H Heenaye Sumser Date: 2023.02.28 15:09:02 -05'00'

Additional Inspector(s)
Lillian Akapong (741771)
Farah Khan (695) was present in this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 15-17, 21-22, 2023

The following intake(s) were inspected in this Critical Incident (CI) inspection:
Intake #00004862 and intake # 00018423 related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee shall ensure that the staff involved in the different aspects of care for a resident, collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Rationale and Summary

A resident was at risk for falls. A review of their care plan indicated they required a specified mobility aid.

A staff member identified that the resident used a different mobility aid to ambulate.

The Director of Care (DOC) stated that the following places were where the plan of care for mobility was documented: the care plan, the Kardex and a sign was placed in a resident's room.

The specified mobility aid was listed on the sign in the resident's room and the Kardex but a different mobility aid was on the care plan.

The DOC confirmed that the written plan of care did not provide clear, consistent direction for a resident when the care plan, the Kardex, and the sign in a resident's room did not complement each other, in the direction related to a resident's mobility.

A resident was at increased risk of not receiving the correct mobility aid as the plan of care was not consistent with and complementing each other.

Sources: Review of a resident's plan of care; Interview with the DOC and other staff.

[740741]

WRITTEN NOTIFICATION: Reporting re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to inform the Director of a critical incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition within one business day after the occurrence of the incident, and followed by a report of the incident.

Rationale and Summary

A resident's clinical record review indicated that they sustained a fall for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition.

A critical incident report was first submitted nine business days after the fall incident.

The Director of Care (DOC) confirmed that the home failed to report the critical incident within one business day, and did not submit a written report within 10 days of the incident.

Sources: Critical incident report, record review of a resident, interview with the DOC.

[740741]

WRITTEN NOTIFICATION: Falls prevention management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, that a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls was completed.

Rationale and Summary

A resident had a fall and a post-fall assessment was not completed.

Registered staff stated that after a resident falls, a post-fall assessment was to be documented on the electronic medical record.

The Director of Care (DOC) acknowledged that the required post-fall assessment at the time of the fall for a resident was not completed.

When the post-fall assessment tool was not completed after a resident had a fall, there was moderate risk to the resident with the possibility of delayed assessment and treatment for their injury.

Sources: Interview with the DOC and other staff; review of a resident's clinical records.

[741771]