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
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Original Public Report

Report Issue Date: December 04, 2023	
Inspection Number: 2023-1220-0004	
Inspection Type: Critical Incident	
Licensee: Six Nations of the Grand River	
Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken	
Lead Inspector Olive Nenzeko (C205)	**Inspector Digital Signature** Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2023.12.14 11:18:11 -05'00'
Additional Inspector(s) Indiana Dixon (000767) Lillian Akapong (741771)	

INSPECTION SUMMARY

Inspection Summary
The inspection occurred onsite on the following date(s): November 1-3, 6-9, 2023

The following intake(s) were inspected:
· Intake: #00018944/ CI #2724-000006-23; Intake: #00019072/ CI #2724-000007-23 and Intake: #00090336/ CI #2724-000023-23 related to unexpected death of a resident.
· Intake: #00021457/ CI #2724-000009-23 related to prevention of abuse and neglect.
· Intake: #00089511/ CI #2724-000020-23 related to prevention of abuse and neglect.
· Intake: #00094656/ CI #2724-000031-23 related to falls prevention and

management.
· Intake: #00098656/ CI #2724-000037-23 related to responsive behaviours.

The following intake was completed in this inspection: Intake: #00021558/ CI #2724-000010-23 related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and secure home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for its residents.
Rationale and Summary
On an identified date, staff acknowledged that the resident accessed a door that

should not have been accessible to the resident, resulting in the resident sustaining an injury.

The Director of Care (DOC) acknowledged that the resident sustained an injury due to having access to an area of the home that should not have been accessible to residents and stated that, the room should have had a barrier to block residents from accessing it.

The home not ensuring that the resident was safe and secured in their environment put the resident's safety at risk, resulting in an injury.

Sources: Interview with DOC, staff, record review, CI report.
[741771]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised to reflect the change in their care needs.

Rationale and Summary
A resident's plan of care was created with no falls prevention interventions.

The resident had an unwitnessed fall, was sent to the hospital, and diagnosed with

an injury. When the resident returned from the hospital, their plan of care was not revised to indicate their fall risk.

During an interview, the Director of Care (DOC) acknowledged that the resident's plan of care was not reviewed or revised when their care needs changed to include falls prevention interventions to help mitigate their fall risk. The DOC noted that the resident's plan of care should have been revised to include the fall and their fall risk level.

Failing to review and revise a resident's plan of care after a fall incident, may place the resident at further risk.

Sources: Critical Incident (CI) report, plan of care and interview with the DOC. [000767]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
When reassessment, revision is required
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's written plan of care was reviewed and revised when the care set out in the plan was not effective.

Rationale and Summary
The Critical Incident (CI) report indicated that the resident had a history of a responsive behaviours.

A review of the resident's progress notes revealed that the home did not review or revise their plan of care to include alternative approaches when the current interventions in place were not effective to mitigate their responsive behaviours risk.

The DOC reviewed the resident's plan of care and identified that based on the dates, the plan of care was not reviewed or revised when not effective and should have been.

The home's failing to review and revise a resident's plan of care when the care set out in the plan was no longer effective, may place the resident's at further risk.

Sources: Critical Incident (CI) report, plan of care, progress notes and interview with the DOC.
[000767]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that an alleged incident of staff to resident abuse was investigated.

Rationale and Summary
The home's Prevention of Abuse and Neglect Policy indicated that any form of

abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated. The policy outlined that promptly and thoroughly investigation of all alleged or reported incidents was required, and that the staff was to identify and address root causes using quality improvement methods and tools and interdisciplinary plan of care strategies.

The DOC confirmed that no investigations were initiated when an alleged incident of physical abuse against the resident was reported to the home.

By failing to investigate the allegation of abuse, this may increase the risk for resident to be harmed.

Sources: Zero Tolerance of the Abuse and Neglect policy and interview with the DOC.
[000767]

WRITTEN NOTIFICATION: Training

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 3.
Training
Additional training — direct care staff
s. 82 (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:
3. Behaviour management.

The licensee has failed to ensure that all direct care staff received additional training, as it relates to behavioural management (responsive behaviours).

Rationale and Summary

In an interview, a staff acknowledged that they did not receive training on responsive behaviours.

A review of the home's training record revealed that the staff had not completed training on responsive behaviours. The staff name was not included in any of the training records provided by the home. This information was also confirmed by the Director of Care (DOC) in an interview.

Failing to train staff member on the home's responsive behaviours procedures, may impact the staff ability to effectively support a resident.

Sources: The home's training record, interview with PSW and the DOC.
[000767]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to themself, including any risk of falling, and interventions to mitigate those risks.

The licensee has failed to ensure that a 24-hour admission care plan was developed for a resident and communicated to direct care staff within 24 hours of admission regarding any risk of falling and interventions to mitigate those risks.

Rationale and summary
Every resident was to have an admission care plan established and communicated to direct care staff within 24 hours of the resident's admission to the home.

The resident was admitted to the home on a specific date; a fall risk assessment completed that date identified that they were a high risk for falls and included falls interventions to mitigate falls; however a 24-hour admission care plan was not developed related to falls. Resident had a fall with injury and their initial care plan related to falls was not in place.

The RAI-MDS coordinator acknowledged that the resident's 24-hour admission care plan for falls was not completed when it should have been.

Failure to develop a 24-hour admission care plan for falls for the resident may have increased the resident's risk of falling, and staff may not have been aware of the resident's falls risk and fall prevention measures.

Sources : Resident's clinical records; Interview with RAI-MDS Coordinator.
[C205]

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that, a resident with a wound, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
On an identified date, the DOC acknowledged that a proper assessment was not done using the IPAD photo application which was the clinically appropriate tool used by the home.

The staff not using the proper assessment tool put the resident's wound at risk for infection.

Sources: Interview with DOC, staff, record review, CI report.
[741771]

WRITTEN NOTIFICATION: Evaluation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)
Evaluation
s. 106 (b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

The licensee has failed to ensure that the Zero Tolerance of Resident Abuse and Neglect Program was evaluated and updated at least annually.

Rationale and Summary
A review of the licensee's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program" indicated that the program policy was last reviewed and updated on a specific month in 2022.

The DOC confirmed that the Zero Tolerance of Resident Abuse and Neglect Program policy, revised on the specific month in 2022 was the home's most current

policy.

Sources: Zero Tolerance of Resident Abuse and Neglect Program policy, and an interview with the DOC
[000767]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (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 (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed of an unexpected death.

Rationale and Summary
On an identified date, the DOC acknowledged that unexpected death should be reported immediately to the ministry and staff did not call the after-hours line.

The home not reporting the unexpected death did not follow the Directors' requirement.

Sources: Interview with DOC, staff, record review, CI report.
[741771]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 4.
Reports re critical incidents
s. 115 (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 (5):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

The licensee has failed to ensure that the Director was immediately informed when a resident was missing from the home and returned with an injury.

Rationale and Summary
A review of the resident's care plan indicated that the resident was a high risk for a responsive behaviour.

The DOC verified that the home did not immediately report the incident to the Director. The DOC acknowledged that the incident should have been reported earlier. The resident was gone from the home before noon and did not return until later in the afternoon. The incident was reported to the Director four days after it had occurred.

Failing to report immediately to the Director that a resident was missing from the home and returned with an injury, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Care Plan, Critical Incident (CI #2724-000037-23) report and interview with DOC.
[000767]