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

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Public Report

Report Issue Date: January 14, 2025
Inspection Number: 2025-1220-0001
Inspection Type: Complaint Critical Incident
Licensee: Six Nations of the Grand River
Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): January 6, 7, 8, 9, 2025

The following intake (s) were inspected:

- Intake: #00130957 - Public complaint – related to Prevention of Abuse and Neglect.
- Intake: #00131300 – [Critical Incident (CI): 2724-000032-24] – related to Prevention of Abuse and Neglect.
- Intake: #00132182 – [CI: 2724-000033-24] – related to Medication Management.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 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

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 allegations of abuse towards a resident was immediately investigated. A staff noted that the incident was investigated several days later.

Sources: Interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1)

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the

Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that allegations of abuse against a resident was immediately reported to the Director. This was acknowledged by the home.

Sources: A review of the Critical Incident Report, and staff interview.

WRITTEN NOTIFICATION: Notification re incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident was notified of the results of an investigation upon completion, as it relates to allegations of abuse against them.

Sources: A resident's clinical records, and staff interview.

WRITTEN NOTIFICATION: Police service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service 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. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was

immediately notified of the allegations of abuse against a resident. A staff noted that the police should have been informed when they became aware of the incident.

Sources: A review of the Critical Incident Report, and staff interview

WRITTEN NOTIFICATION: Evaluation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(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 an evaluation of the home's abuse and neglect program was completed in 2024 to determine the effectiveness of their policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents.

Sources: A review of the home's Zero Tolerance of Abuse and Neglect policy, and staff interview.

WRITTEN NOTIFICATION: Evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (e)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(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.

The licensee has failed to provide a written record of the home's evaluation of the changes that were made to improve the effectiveness of the program. A staff noted that they did not have a written record, as the program was not evaluated annually as required.

Sources: A review of the home's Zero Tolerance of Abuse and Neglect Program policy, and staff interview.

WRITTEN NOTIFICATION: Medication management system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that written policies and protocols developed for medication management system, specifically the Management of Narcotics and Controlled Drugs' Policy, was implemented for a resident. This was confirmed by a member of the home's staffing team.

Sources: Management of Insulin, Narcotics and Controlled Drugs RC-16-01-13 (last reviewed March 2023); and staff interview.