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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Public Report

Report Issue Date: February 10, 2025

Inspection Number: 2025-1220-0002

Inspection Type:
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 dates: February 3-5, and 10, 2025.

The following intakes were inspected:

- Intake: #00133817, Critical Incident (CI) 2724-000035-24 related to falls prevention and management; and,
- Intake: #00135997, CI 2724-000002-25 related to alleged resident to resident physical abuse.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care provided clear direction to care staff when it contained conflicting information regarding the level of assistance required for activities of daily living (ADLs). A resident's care plan specified that some of the resident's ADLs was both independent with supervision and required extensive to total assistance from staff. The care plan also indicated the resident walked independently without any assistive devices despite using one for the past two months.

The home's Resident Assessment Instrument (RAI) coordinator acknowledged the conflicting information and made corrections so that the resident's plan of care reflected their current status and needs.

Sources: resident's clinical records; observations; interviews with the RAI Coordinator.

Date Remedy Implemented: February 5, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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. Staff reported that the plan of care for the resident had not been updated when the resident's care needs changed in relation to responsive behaviour interventions. The staff updated the plan of care the same day.

Sources: resident's clinical records, interview with staff.

Date Remedy Implemented: February 4, 2025

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that an intervention under the home's falls prevention and management program was documented for a resident. The resident's plan of care specified that staff were to monitor a falls prevention

intervention which a personal support worker (PSW) said were being done and that staff were to document the completed task in Point of Care (POC). A review of POC documentation showed that on several days, in a two month period, it was not completed multiple times.

Sources: resident's clinical records; and interview with a PSW.