Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 13, 14, 15, 27, Dec 14, 19, 2012	2012_027192_0053	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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Education Co-ordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Services Supervisor, Registered Dietitian, and residents related to H-002091-12.

During the course of the inspection, the inspector(s) reviewed medical records, observed the provision of care and interaction between residents and staff, observed meal service, and reviewed policy and procedure.

The following Inspection Protocols were used during this inspection:

Dining Observation

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaints that have been received concerning the care of a resident of the home to the Director. [s. 22. (1)]

The licensee received a letter of complaint related to the abuse of a resident residing in the home in 2012. Documentation review and interview confirm that the licensee failed to forward the written complaint to the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protected residents from abuse by anyone. [s. 19. (1)]

a) In June 2012 an incident between resident 001 and resident 004, occurred that resulted in both residents being injured. Resident 004 was pushed in the wheelchair, causing it to tip over backwards and resulting in injury. Resident 001 was struck with an item by resident 004, resulting in injury to resident 001.

There had been a prior incident between resident 001, and resident 004, that should have alerted the home to further potential negative interaction between the two residents. Interventions in place were ineffective in protecting resident 004 and resident 001 from injury.

b) In September 2012 resident 003 was pushed by resident 001 causing resident 003 to fall and sustain an injury. Head Injury Routine was initiated by the home, the resident was sent to the hospital for assessment and returned to the home.

Interview confirms that resident 001 was known to attempt to elope the home through the main entrance and was known to demonstrate physical aggression when denied access. In September 2012 a visitor entering the home with a co-resident was punched and hit by resident 001.

Interventions in place to protect resident 003 and others from the actions of resident 001 were ineffective.

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 ensuring that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that includes the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any; every date on which any response was provided to the complainant and a description of the response and any response made by the complainant. [r. 101. (2)]

The licensee received a letter of complaint in 2012. In November 2012, the letter of complaint is noted to be included in the home's complaint binder but documentation review and interview confirm that there is no record of the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

2. The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, there has been a response made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. [r. 101. (1) 3.]

The licensee received a written complaint in 2012. Documentation review and interview conducted November 2012 confirm that the complainant has not received a response indicating what the licensee has done to resolve the complaint or that the licensee believes the complainant to be unfounded and the reasons for the belief.

3. The licensee failed to ensure that every written complaint made to the licensee concerning the care of a resident has been investigated, resolved where possible and response provided within 10 business days of receipt of the complaint. [r. 101. (1) 1.]

The licensee was sent a complaint in 2012. The complaint is present in the home's complaint binder in November 2012 - no date of receipt of the complaint is identified in the documentation provided. Documentation review and interview confirm that the home has not documented an investigation into the complaint and has not responded to the complainant with regard to concerns identified within 10 business days of receipt of the complaint.

Issued on this 19th day of December, 2012

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

Debra Laurie (659)