Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2015	2015_201167_0002	H-001793-15	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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 16, 19, 23, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), registered staff, personal support worker staff, identified residents and family members and the Staff Educator.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 19. Duty to protect

Specifically failed to comply with the following:

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 has failed to ensure that resident #002 was protected from abuse by resident #001.

i. On an identified date in 2014, resident #003 reportedly witnessed an incident of abuse between resident #001 and resident #002. The incident reportedly took place near the nurses' station. Resident #003 intervened by telling resident #001 to get away. Resident #003 alerted nursing staff who removed resident #001 from the area. It was noted that resident #001 had a history of displaying this type of behaviour and resident #002 had significant cognitive impairment and was not able to defend themselves against resident #001.
ii. During an interview with resident #003, they indicated that they reported the incident to the resident's #002's family and the nursing staff. This was confirmed through documentation found in resident #002's progress notes.
iii. The registered staff who received the complaint from the resident's family and resident #003 made a notation in resident #002's progress notes and reported the incident to the Director of Care the next day.
iv. The Director of Care met with the resident's #002's family, initiated a critical incident report and reported the incident to the police. [s. 19. (1)]

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 to ensure that resident #002 and other residents are protected from abuse by resident #001, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the resident #001's plan of care was reviewed and revised when the care set out in their plan of care was not effective.

i. Resident #001 was noted to display inappropriate behaviours towards staff during care and towards female residents. The resident was being followed by the Behavioural Support Outreach Team and it was noted that one of the interventions suggested by them to manage the resident's inappropriate behaviours towards staff was to have two staff provide their care.
ii. The progress notes located in the resident's health file also confirmed that the resident should have two staff to provide their care. The progress notes also indicated that if the behaviour continued that a different staff member should be assigned to assist with the resident's care. The progress notes
indicated that staff would continue to monitor the resident every half hour.
iii. During a review of the document that the home referred to as the care plan and confirmed by the DOC to be the most current for the resident, it was noted that the above interventions were never added to the resident's care plan.
iv. A personal support worker staff interviewed indicated that they provide care to resident #001 by themselves and were not aware of any direction to use two staff to provide the resident's care.
v. During an interview with the DOC, they confirmed that the resident should have two staff to provide care and that these interventions should have been added to the resident's care plan. [s. 6. (10) (c)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports.

i. The home's policy [Residents' Rights and Safety and Abuse Prevention] last reviewed in January 2014 directed staff to immediately report to their supervisor or the Manager or the Director of Health Services if there were reasonable grounds to suspect that an abuse of a resident has occurred.
ii. On an identified date in 2014, resident #001 was observed by resident #003 to have displayed abusive behaviour towards resident #002. Resident #003 reported the incident to resident #002's family member and nursing staff the next day.
iii. The nursing staff documented in resident #002's progress notes that the incident was reported on but did not immediately notify their supervisor or the Manager or the Director of Health Services.
iv. The incident was not reported to the Administrator/Director of Care until one day later and the critical incident report was not submitted to the Director until that day.[s. 20. (1)]

Issued on this 27th day of January, 2015

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

Original report signed by the inspector.