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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 13, 2017	2017_558123_0003	006260-17	Resident Quality Inspection

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

MELODY GRAY (123), JESSICA PALADINO (586), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 23, 24, 27, 28, 29, April 6 and 13, 2017

During the inspection Inspectors toured the home; interviewed residents, family members, and staff; reviewed residents' records; reviewed the home's records including policies and procedures and observed medication administration and infection prevention and control practices.
Concurrent inspections conducted during this inspection: follow-up inspection #021463-16 and complaint inspection #026965-16 related to food production, Residents' Bill of Rights and dealing with complaints

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), the Acting Nursing Clerk, the cook, the Activity Coordinator, registered nursing staff, the Acting Staff Development Nurse, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, the Environmental Services Supervisor, the Pharmacist, the Food service Supervisor, and the Administrator/Director of Care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Sufficient Staffing

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

- **16 WN(s)**
- **9 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2016_267528_0010	168

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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that there was a written plan of care for each resident that sets out, (a) the planned care for the resident.

The record of resident #013 was reviewed including the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment dated February, 2017 and it was noted that the resident experienced mild pain less than daily. The resident's care plan was reviewed and it did not include a focus, goals or interventions related to potential or actual pain.
The RAI-MDS Coordinator was interviewed and reported that staff documented the resident's pain and it was included in the quarterly assessment. They confirmed that the plan of care for resident #013 was not based on an assessment of the resident's pain. [s. 6. (1) (a)]

2. The licensee failed to ensure that the written plan of care for the resident gave clear directions to staff and others who provided direct care to the resident.

The record of resident #014 was reviewed and it was noted that they had a fall without injury in February, 2017.
The plan of care for the resident related to transfers identified that they required the assistance of one person for all transfers and that staff were to raise the bed to the highest position when the resident was not in the bed to prevent resident self-transfers.
The plan of care related to falls prevention identified that staff were to lower the resident's bed as close to the floor as possible.
The Resident Care Information Card, posted in the resident's room, above their bed, identified that they required two person assistance to transfer.
The resident was observed on an identified date in March, 2017 during a transfer with Personal Support Worker (PSW) #103.
The PSW was interviewed and they verified that the resident required the assistance of one person for all transfers unless they demonstrated responsive behaviors and would then require additional assistance. PSW #103 also verified that the Resident Care Information Card, posted at the bedside, was not consistent with the care provided. However, verbalized that they confirmed with the charge nurse that the resident would required the assistance of two staff for transfers in the event that the resident displayed behaviors.
The resident's bed was observed on two identified dates in March, 2017 to be in a raised position when the resident was not in bed and in a lowered position when the resident was in bed.
Registered staff #108 was interviewed and they indicated that the Resident Care Information Card, posted in the resident's room, was to give direction to the staff who provided direct care to the resident, in addition to the plan of care and that the two records should be consistent. Registered staff #108 reviewed the plan of care related to transfers and fall prevention and the Resident Care Information Card. They confirmed that the documents did not give clear direction to staff who provided direct care to the resident related to level of assistance with transfers and to positions of the bed.
The plan of care related to transfers and fall prevention did not give clear direction to staff who provided direct care to resident #014.

The record of resident #017 was reviewed and it was noted that they were independent with mobility and transfers. The record indicated that the resident fell twice while ambulating in March, 2017 and sustained no injuries as a result of the falls.

The resident's plan of care was reviewed. The focus related to mobility identified that the resident did not use bed rails on their bed. However, the focus related to falls prevention noted that two bed rails were to be up at all times when the resident was in bed for safety.
Resident #017 was observed to self-transfer and ambulate without assistance or mobility aids on two identified dates in March, 2017. The resident was not observed in bed during the inspection; however, bed side rails were observed to be in the lowered position when the bed was unoccupied.
Registered staff #108 was interviewed and they reviewed the resident's plan of care with the Inspector. Registered staff #108 confirmed that the plan of care related to mobility and falls prevention, did not give clear direction related to the use of bed side rails.
The plan of care for resident #017 did not give clear direction to staff who provided direct care. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

The record of resident #016 including the progress notes and care plan, was reviewed. The resident was identified as being at a high nutritional risk. They were noted to have been on a mechanically altered texture diet with a specified degree of thickened fluids when they began experiencing a decline in their eating ability. The progress notes indicated that: Between August and September, 2016, various notes identified difficulty swallowing. The resident was sent to hospital and returned with a change in their diet order and a device in place.

The day after the resident returned to the home, the Registered Dietitian (RD) progress note indicated the RD noted that staff had documented incidents of the resident having difficulty with chewing and or swallowing; that new strategies were suggested by staff and approved by resident's family and no referral to RD was made by staff.
Further review of the resident's record did not reveal any documentation of referrals made to the RD regarding their eating decline or the change in the interventions related to eating, including eating in bed.
The RD and the Food Services Manager (FSM) were interviewed and they confirmed that staff were trialing different interventions related to resident #016 eating problems and or difficulties without consulting the RD and that the staff did not inform them of the eating difficulties the resident was experiencing. The RD confirmed that they were not

given the opportunity to collaborate with the nursing staff in the assessment of resident #016 related to eating. (586)

The record of resident #019 was reviewed and it was noted that they had an identified device in place. The use of the device was recorded in the resident's Minimum Data Set (MDS) assessment dated December, 2016 and was supported by the Resident Assessment Protocol (RAP) completed for the same time period. The resident's MDS assessment dated March, 2017 did not include the use of the device. The assessment indicated there was no change in the status of the resident's urinary continence compared to their status 90 days prior. A further review of the clinical record confirmed that the resident used the device in December, 2016; it was discontinued in February, 2017 and the resident no longer used it.
Registered staff #108 was interviewed and they verified that in February, 2017 the resident had a change in their continence status from the December, 2016 MDS assessment. They also confirmed that the March, 2017 MDS assessment which noted that the resident did not have a change in their continence status was not consistent with the previous assessment as the resident's continence changed in February, 2017.
The staff and others involved in the different aspects of care did not collaborate with each other in the assessment of resident #019 related to continence so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

The record of resident #016 including the care plan was reviewed. The plan of care related to fall prevention indicated that the resident required the use of a device when in bed. Observation of the resident on two identified dates in March, 2017 revealed that the resident did not have the device in place while they were in bed.
PSW #112, registered staff members #118 and #115 were interviewed and they confirmed that the resident no longer required the use of the device. Registered staff #118 confirmed the plan of care related to fall prevention was not updated when the resident's care needs changed and the intervention was no longer necessary. (586)

The record of resident #019 was reviewed and it was noted that in December, 2016 the resident returned from the hospital with an identified device in place and a physician's order for the device to be used.

The Quarterly Medication Review dated January, 2017 indicated that the device was not reordered and provided direction to discontinue all previous orders. No physician's order for the continued use of the device was found in the resident's record.
Review of the progress notes identified that the device remained in place following the Quarterly Medication review. Progress note documentation on an identified date in February, 2017 by registered staff #117 indicated that the staff member could not find any medical orders for the device in the resident's record. Progress notes also indicated that the device was removed as per physician's order on that day. The resident's care plans were reviewed and they did not include any information related to the resident having the device in place from December, 2016 until February, 2017.
Registered staff #108 was interviewed and confirmed the information above.
The plan of care was not reviewed and revised when the care needs of resident #019 changed. [s. 6. (10) (b)]

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: There is a written plan of care for each resident that sets out, the planned care for the resident and give clear directions to staff and others who provide direct care to the resident. The staff and others involved in the different aspects of care of the residents collaborate with each other, in the assessment of the residents so that their assessments are integrated and are consistent with and complement each other and in the development and implementation of the plan of care so that the different aspects of care are integrated and consistent with and complement each other. The residents are reassessed and the plans of care reviewed and revised at least every six months and at any other time when, the residents' care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home had a policy and procedure, Continence of Bowel and Bladder, revised August, 2015 as required under Ontario Regulation section 48 (1).
This procedure identified that residents should be reassessed when there was any change in the resident's health status that affected continence. The change was to be recorded in the Resident Assessment Instrument Minimum Data Set (RAI-MDS) and the seven day observation record.
On request, the RAI-MDS Coordinator produced a blank copy of the seven day observation record form which was to be completed when the resident had a change in their continence status.

The record of resident #019 was reviewed and it was noted that they had a change in continence status on an identified date in December, 2016 when they returned from the hospital with an identified device in place and on an identified date in February, 2017 when the device was removed as ordered by the physician. A completed observation record for the above dates could not be located in the resident's record.
The Administrator was interviewed by Inspector #123 and verified that the resident did not have a seven day observation record completed when they had a change in continence status as required by the home's procedure.

The home's policy and procedure related to continence management was not complied with.

The home had a policy and procedure, Referral to the Dietitian, #FNS-CN-085, effective June 1, 2009 as required under Long-Term Care Homes Act, 2007, section 11. (1). The policy was reviewed and it directed registered staff to complete a referral form when a nutritional concern was identified and for any other staff to bring it to the attention of the registered staff.

The home had a policy and procedure, related to an identified device as required under the Long-Term Care Homes Act, 2007, section 11. (1). The policy was reviewed and indicated that the RD would complete an initial assessment when a resident arrived at the facility with the identified device.

The record of resident #019 including progress notes was reviewed and it was noted that they were in the hospital for an identified number of days in December, 2016. Progress notes documentation of two identified dates in December, 2016 indicated that the hospital contacted the home regarding the consideration of identified device for the resident. A progress note of an identified date in December, 2016 indicated that the hospital RD contacted the home to discuss the identified device.
The Dietary Referrals binder and progress notes were reviewed and did not include a RD referral for resident #019 upon return from hospital with the identified device. The resident was not seen by the RD until eight days after their return from the hospital after the RD received a verbal referral about another dietary concern.

Registered staff #115 was interviewed and they indicated that it was the home's procedure to refer a resident to the RD when there was a change in the resident's diet in hospital or when they returned from the hospital with specific dietary orders. The RD was interviewed by Inspector #586 and confirmed that they did not receive a referral to assess resident #019's use of the identified device for eating upon the resident's readmission from hospital and that this change in eating was considered a significant change in the resident's health condition.

The home did not ensure that the home's policies and procedures regarding referrals to the RD and the identified device were complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record relating to each annual evaluation of the falls prevention and management program, that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented was kept.

The Administrator-Director of Care (DOC) was interviewed and identified that the fall prevention and management program was reviewed during the Professional Advisory Committee (PAC) meeting in January, 2017.
The home's records including the January, 2017 PAC Meeting Minutes were reviewed. The minutes included: a summary of the number of residents who had fallen and number of injuries resulting from falls over the past three years; the number of residents who used restraints and Personal Assistance Services Devices (PASDs) and noted that there were three residents with an ongoing history of falls.
The PAC meeting minutes did not include a summary of the changes made to the falls prevention and management program nor the date that those changes were implemented.
The Administrator was interviewed by inspectors #683 and #123 and confirmed that the evaluation of the fall prevention and management program did not include a summary of the changes made or the date that those changes were implemented.

The home's annual evaluation of the fall prevention and management program, did not included a written record of the program that included a summary of changes made and the date that those changes were implemented. [s. 30. (1) 4.]

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 ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident fell, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The record of resident #013 was reviewed including progress notes. It was noted that on an identified date in March, 2017 the resident fell and sustained an injury.
Documentation of a post-fall assessment related to the fall was not found in the resident's record.
The Acting Staff Development Nurse was interviewed and reported that whenever a resident falls and sustains injury they are assessed using the Falls Risk Assessment Tool (FRAT) tool. They also confirmed that a post fall assessment was not completed using the FRAT tool when resident #013 fell and sustained an injury in March, 2017.

A post-fall assessment using a clinically appropriate instrument that was specifically designed was not conducted of resident #013 when they fell and sustained an injury in March, 2017. [s. 49. (2)]

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 that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Residents' Council advised the licensee of concerns or recommendation, the licensee, within 10 days of receiving the advice, responded to the Residents' Council in writing.

i. On an identified date in July, 2016 resident #021 submitted a concern related to kitchen staffing, food safety and overall quality of care in the home. The concern form was signed by nine residents. The Administrator/DOC responded to the concern five days later stating that they would attend Residents' Council meeting to review the concerns and explain how things were done.
Residents' Council Meeting Minutes dated August, 2016 were reviewed and there was no documentation to confirm that the Administrator/DOC attended the meeting or discussed the concerns of the residents as per the written response.

ii. Review of the Residents' Council Meeting Minutes dated February, 2017 identified concerns about the cleaning of a resident bathroom.
The Activity Coordinator was interviewed and indicated that the concern had been dealt with immediately; however, a response to the concern nor documentation of the resolution were documented.

iii. Activity Coordinator reported that at the Residents' Council meeting in February, 2017 department managers were brought in, one at a time, to discuss resident concerns relating to their department.
The February, 2017 Residents' Council Meeting Minutes were reviewed and there was no documentation found of any concerns raised by residents, nor of the department managers attending the meeting and addressing any concerns.

The Activity Coordinator also reported that when concerns were raised at Residents' Council meetings, small concerns were dealt with immediately and larger concerns were documented and submitted to the Administrator/DOC by using a Resident Council and Family Council Concern Form.
The review of the Residents' Council Meeting Minutes did not identify any concern forms noted above or any responses by the Administrator/DOC and the home could not produce any documentation related to dealing with the concerns as noted above.

The home did not respond to the concerns or recommendations of the Residents' Council in writing within 10 days. [s. 57. (2)]

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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, and height upon admission and annually thereafter.

ii.The record of resident #019 was reviewed and it was noted that they were admitted to the home on an identified date in October, 2016. No documentation of the resident's height at admission was found in the resident's record nor was documentation found of resident refusing height measurement. RD progress note of the quarterly nutrition review dated 56 days after the resident's admission indicated that resident #019's height was not documented. The height was not measured until requested by the RD 74 days after admission.

The RD was interviewed and reported that the staff allegedly reported that they had not measured the resident's height related to their medical diagnosis.

ii. The record of resident #019 was reviewed and it was noted that they were admitted on an identified date in October, 2016 and an admission weight of an identified number of kilograms (kg) was taken eight days later. The record indicated that the resident was in hospital for an identified number of days in December, 2016. As per dietary progress note, their weight on an identified date in December, 2016 in hospital was an identified number of kg according to the hospital's RD. An updated weight was not found to be documented in the resident's record upon their return from hospital. It was noted by the RD in a December, 2016 progress note for the quarterly nutrition review that an updated weight was not recorded; however, the RD did not request this information. The resident's weight was not measured until requested by the RD in January, 2017.

The RD was interviewed and confirmed that the resident's weights were not documented until 74 days after admission. They also reported that they required updated height and weight measurements in order to accurately determine the resident's nutritional requirements related to dietary intake. They confirmed the resident's height was not taken upon admission and weights were not taken monthly thereafter as above. [s. 68. (2) (e)]

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 the nutrition care and hydration programs include, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, and body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: A change of 7.5 per cent of body weight, or more, over three months.

The record of resident #019 was reviewed. The resident was noted to be at a high nutritional risk due to identified factors. The resident's weight upon admission on an identified date in October, 2016, was noted to be an identified number of kg. Their next documented weight on an identified date in January, 2017 was an identified number of kg. This change in body weight represented a weight loss 15.7 per cent over three months.
The RD progress note of the quarterly nutrition assessment, dated March, 2017 indicated: "[Point Click Care] triggered [weight] loss this month, no referral to RD". Review of the Dietary Referrals binder and the resident's record did not identify documentation of any referrals made to the RD for the resident's significant weight loss since admission to the home.

The RD was interviewed and confirmed the above information including that when resident #019 had a change of 7.5 percent of body weight, or more, over three months they were not assessed using an interdisciplinary approach and that actions were not taken. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated: A change of 7.5 per cent of body weight, or more, over three months, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council was sought out in developing and carrying out the annual resident and family satisfaction survey, and in acting on its results.

Interview with residents #028 and #029 indicated that Residents' Council was not asked to review the annual satisfaction survey questions.

The Activity Coordinator was interviewed and indicated that the Residents' Council was offered the opportunity to provide feedback on the satisfaction survey yearly, near the end of the fiscal year.

The Residents' Council Meeting Minutes from April, 2016 to February, 2017 were reviewed and no documentation was found to confirm that the licensee sought the advice of the Residents' Council in developing and carrying out the satisfaction survey.

The Activity Coordinator was again interviewed and confirmed that there was no

documentation to support the information they had reported and that it was an oversight that this information was not included in the Residents' Council Meeting Minutes. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the satisfaction survey were documented and made available to the Residents' Council and the Family Council, in order to seek their advice in acting on its results.

Residents #028 and #029 were interviewed and indicated that Residents' Council was not asked to review the results of the 2016 annual resident and family satisfaction survey.
The Activity Coordinator was interviewed reported that the Residents' Council was offered the opportunity to review the results of the satisfaction survey yearly.

The Residents' Council Meeting Minutes from April, 2016 to February, 2017 were reviewed and there was no documentation found to confirm that the home made the results of the satisfaction survey available to the Residents' Council in order to seek their advice about the survey results.

The Activity Coordinator was again interviewed and confirmed that there was no documentation to support their verbal reports and that it was an oversight that this information was not included in the meeting minutes.

The home did not ensure that the results of the annual resident and family satisfaction survey were documented and made available to the Residents' Council in order to seek their advice. [s. 85. (4) (a)]

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 the advice of the Residents' Council is sought out in developing and carrying out the annual resident and family satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as of January 1, 2011, the DONPC worked regularly in that position on site for at least the following amount of time per week:
1. In a home with 19 licensed beds or fewer, at least 4 hours
2. In a home with 20 to 29 licensed beds, at least 8 hours
3. In a home with 30 to 39 licensed beds, at least 16 hours
4. In a home with 40 to 64 licensed beds, at least 24 hours
5. In a home with 65 or more licensed beds, at least 35 hours

The Administrator and or Director of Nursing and Personal Care (DONPC) was noted to be away from the home for an identified one week period. There was no Registered Nurse (RN) working in the position of the DONPC in the home during that week.
The Acting Administrator was interviewed and reported that they were not a Registered Nurse and that the RN who usually worked in the DONPC position while the Administrator/DONPC was away from the home had left the home June, 2016. They confirmed that the home did not have a RN in the position of the DONPC who worked regularly in that position on site for at least 24 hours per week for an identified week in 2017. [s. 213. (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 the DONPC works regularly in that position on site for at least the following amount of time per week: 4. In a home with 40 to 64 licensed beds, at least 24 hours, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Iroquois Lodge Nursing Home is a long term care home with a licensed capacity of 50 beds.
The Administrator/DOC was interviewed and verified the staffing pattern for the home included at least one RN, not including the DOC, on duty and present at all times, in addition to a mix of Registered Practical Nurses (RPNs) and PSWs to meet the nursing and personal care needs of the residents.

The Administrator/DOC was interviewed by Inspector #123 and they reported that currently the home had vacant RN positions, which they were unable to fill with their recruitment efforts in various media. The home also had vacant shifts as a result of staff vacations and illnesses which resulted in the home having additional vacant shifts which needed to be filled.
The Administrator indicated that the home consistently offered additional shifts and overtime to their RNs in order to fill these vacant shifts. When the RNs employed by the home were unwilling or unable to work the vacant shifts, the home used RNs employed by an employment agency, with the Administrator/DOC on call to provide RN coverage 24 hours a day seven days a week.
The Registered Nurses Staffing Schedules from January 1, 2017 until February 28, 2017 were reviewed and it was confirmed that over the identified time period there were over 40 occasions when the only RN in the home was an agency RN, with the Administrator/DOC on call.
It was verified by the Administrator/DOC that the agency RNs were not members of the regular nursing staff.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to, preserver taste, nutritive value, appearance and food quality.

Resident #025 reported that rotten bananas were served during snack pass the previous day.
During afternoon snack pass on an identified date in March, 2017 three over-ripened bananas were observed on the snack cart, two having split open and one with a hole that was oozing a sticky liquid.
The PSW completing the snack pass was interviewed and acknowledged that the residents were served food that had compromised appearance and quality. [s. 72. (3) (a)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received training as required in any other areas as provided for in the regulations.

Ontario Regulation 79/10 section 221 identified that staff who provided direct care to residents must receive training in the areas of falls prevention and management on an annual basis as required under LTCHA, 2007 subsection 76 (7).

The Acting Staff Development Nurse provided a record of all falls prevention and management in-service training completed in 2016, including attendance records. Attendance records provided were reviewed and identified that only nine staff members received the falls training in 2016.
The Administrator/DOC was interviewed by inspectors #683 and #123 and confirmed that the training completed in February, 2016 was the only re-training provided on falls prevention and management for staff in 2016.
The Administrator/DOC acknowledged that all staff who provided direct care to residents did not receive annual training on falls prevention and management in 2016. [s. 76. (2) 11.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that, there was a process to report and locate residents' lost clothing and personal items.

The record of resident #018 who was noted to be cognitively alert, was reviewed and it indicated that they reported to the home that they lost an identified sum of money.

The home was requested to produce evidence that procedures were developed and implemented to locate the residents' personal belongings. The home produced one page document related to residents' lost clothing. There was no evidence produced of the home having developed and implemented a process to locate residents' lost personal items.

Acting Administrator/DOC was interviewed reported residents are informed not to have valuables. They could keep valuables in medication cart or in the business office and indicated that staff would help to search for residents' missing personal items. [s. 89. (1) (a) (iii)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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:
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; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, (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 actions was 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.

A review of the Complaints Binder and Log identified the following:
A. According to a Resident Feedback and Concern Form, resident #025 made a complaint on an identified date in March, 2017 regarding a situation at meal times and made a request for a change to happen to address the situation. This concern was assigned to the nursing department for follow up.
The Administrator/DOC investigated the concern the same day according to the form. However, the resident's request was not granted due to other contributing factors.
The form indicated that the Administrator/DOC signed the form as completed on the following day, despite the fact the the concern was still present and no action was taken to resolve the issue.
The Administrator/DOC was interviewed by Inspectors #123 and #683 and identified that a response was provided to the complainant prior to form being completed and that the resident was informed of the other factors which needed to be taken into consideration to resolve the concern. They verified that a record was not maintained of the date that a response was made to the complainant nor the response in turn made by the complainant.

B. According to a Resident Feedback and Concern Form, resident #021 made a complaint on an identified date in August, 2016 regarding the administration of their medications. This concern was assigned to the nursing department for follow up. The Administrator/DOC investigated the concern. However, the document in the Complaints Log did not include the date that this investigation was completed.
The Administrator/DOC was interviewed by Inspectors #123 and #683 and confirmed the above information.

C. The home received a written complaint from the Family Council which the Administrator/DOC noted they received on an identified date in December, 2016 in their letter of response dated the following day.
A review of the letter of complaint identified 26 issues which the council reported to the home on behalf of a group of residents who wished to remain anonymous.
The Administrator/DOC was interviewed by Inspectors #123 and #683 and indicated that in their opinion a number of the issues and or concerns identified in the letter were up to five months old and or sufficient information was not provided in the letter to investigate the issues fully.
A review of the response to the written letter of complaint and the Complaints Log did not consistently include the following for the issues and or concerns identified, as applicable:

i. if there was an investigation completed into the issue and or concern
ii. what the licensee did to resolve the concern, including if appropriate the dates of action taken and any follow up action required
iii. the reasons why the licensee believed that the concern was unfounded
iv. the final resolution to the issues and or concerns
v. any response made by the complainant.

The Administrator/DOC verified that the home did not provide all of the required information to the Family Council regarding the issues in the complaint nor maintained a written record of the actions taken, when applicable, related to the issues and or concerns identified. [s. 101. (2)]

2. The licensee failed to ensure that the documented record of complaints received was reviewed and analyzed for trends, at least quarterly.

A review of the 2016 Complaints Log included the date the complaint and concern was received, a general description of the issue and resolution or follow up taken.
The Acting Staff Development Nurse was not able to locate a review of the complaints or analysis for trends on request.
Interview with the Administrator/DOC by Inspectors #123 and #683 confirmed that the home did not review the documented record of complaints and analyze the record for trends at least quarterly. [s. 101. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is, a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's Substitute Decision-Maker (SDM), if any, the Director of Nursing and Personal Care (DONPC), the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's Medication Incident reports were reviewed and did not include the above information. The Administrator was interviewed and confirmed that the resident; the SDM and physician were not notified for every incident. [s. 135. (1)]

2. The licensee has failed to ensure that a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b)

The home was requested to provide the quarterly review of medication incident records. The home did not provide the requested records. The Administrator reported that the quarterly medication incident review records were not completed. [s. 135. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system were communicated to the Residents' Council on an ongoing basis.

The Activity Coordinator was interviewed and they reported that the Residents' Council was regularly informed of quality improvement measures in the home including new chairs, a new bathtub and a new fireplace. They also indicated that in November, 2016 the Residents' Council was informed about plans for a re-building of the facility and were provided the opportunity to provide input into the design.

The Residents' Council meeting minutes from April, 2016 to February, 2017 were reviewed and there was no documentation found to confirm that the any of the above information regarding quality improvement was in fact communicated to the to the Residents' Council, nor any documentation that the Residents' Council was able to provide their input. [s. 228. 3.]

Issued on this 23rd day of June, 2017

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

Original report signed by the inspector.