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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 19, 2023	
Inspection Number: 2023-1220-0003	
Inspection Type: Complaint, Critical Incident, Follow up	
Licensee: Six Nations of the Grand River	
Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken	
Lead Inspector Sydney Withers (740735)	**Inspector Digital Signature** Sydney Withers Digitally signed by Sydney Withers Date: 2023.10.31 12:55:21 -04'00'
Additional Inspector Karlee Zwierschke (740732)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 28-31, September 1, 5-8, 11, 13-14, 18-20, 22, 25-26, 2023

The following intakes were inspected:

- Intake 00014401/ CI# 2724-000011-22 was related to prevention of abuse and neglect;
- Intake 00091147 was related to concerns with skin and wound care, plan of care and housekeeping;
- Intake 00091308 and intake 00093922 were related to skin and wound care;
- Intake 00095337 was related to medication management; and
- Intake 00093868 was a follow-up related to the safe use of transferring devices.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order was found to be in compliance:

Order #001 from Inspection #2023-1220-0002 related to O. Reg. 246/22, s. 40 inspected by Karlee Zwierschke (740732)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of Licensee to Comply

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
A resident demonstrated altered skin integrity and was to receive a nutrition intervention to support wound healing. Documentation and an interview with registered nursing staff indicated that the intervention was not available for a period of one week, therefore was not provided to the resident. The Food Service Supervisor (FSS) stated they were not informed that the intervention was not available during that time.

Failure to provide the resident with the nutrition intervention as specified in their plan of care may have impacted their intake, with potential implications for wound healing.

Sources: Resident clinical record, interviews with staff and FSS. [740735]

WRITTEN NOTIFICATION: When Reassessment, Revision is Required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their care needs changed.

Rationale and Summary
A) A resident demonstrated altered skin integrity, and pressure from contact with surfaces was identified by registered nursing staff as contributing to their altered skin integrity on an identified date in 2022. Direction to reposition the resident was added to the plan of care in May 2023. The Resident Assessment Instrument (RAI) Coordinator acknowledged that direction for repositioning the resident should have been added to the plan of care when the resident demonstrated issues with skin integrity in 2022.

Failure to review and revise the resident's plan of care when their positioning needs changed may have resulted in inconsistent care.

Sources: Resident clinical record, interview with RAI Coordinator. [740735]

B) A resident had multiple open wounds, which deteriorated on an identified date. The resident indicated that they received a bath. Registered nursing staff acknowledged that the resident's plan of care should have been revised with direction to only provide a bed bath when their wounds were deteriorating.

Failure to revise the resident's plan of care may have resulted in the resident not receiving the clinically appropriate care, therefore increasing the risk of infection and further wound deterioration.

Sources: Resident clinical record, bath list, interviews with resident and staff. [740735]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from sexual abuse by a staff member.

Section two of the Ontario Regulation (O. Reg.) 246/22 defined sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

Rationale and Summary
On an identified date, a staff member witnessed another staff member in a sexual encounter with a resident. The Administrator acknowledged that this incident of sexual abuse was substantiated during their investigation.

Sources: Resident clinical records, interviews with staff and Administrator. [740732]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that an alleged incident of sexual abuse of a resident was reported to the Director immediately.

Rationale and Summary
A Critical Incident (CI) occurred on an identified date but was not reported until the following day. The Administrator confirmed that this incident should have been reported immediately.

Sources: CI report, interview with Administrator. [740732]

WRITTEN NOTIFICATION: Doors in a Home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that all doors leading to the outside of the home were kept locked.

Rationale and Summary
During the inspection, a door at the back of the long-term care home (LTCH) was not locked and there were no staff present to monitor traffic through the doorway. The door was being used as a main entrance during ongoing construction at the front of the LTCH and led to a staff area at the back of the home which was accessible to residents. The Administrator indicated that the door was not kept locked during the day between 0700-1930 hours for ease of access during construction, and that the expectation was for staff to monitor the back door during the hours it was unlocked. They acknowledged that the back door should have been kept locked.

Failure to ensure that a door leading to the outside of the home was kept locked posed a safety and security risk to residents.

Sources: Initial door observation, follow-up observation, interviews with Administrator and staff. [740735]

WRITTEN NOTIFICATION: Skin and Wound Care Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.

The licensee has failed to ensure that the home's skin and wound care program was followed for residents #001 and #004.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a skin and wound care program which included treatment and interventions, and that it was complied with.

Specifically, staff did not comply with Appendix Eight (8) of the "Wound Care Management" policy, titled "Management of Skin Rashes, Lesions and Irritations Guidelines".

Rationale and Summary
A) Resident #001 demonstrated altered skin integrity and pressure from contact with surfaces was identified as contributing to their open wounds. Documentation indicated that resident #001 agreed to an intervention to manage their wounds. Appendix 8 of the home's "Wound Care Management" policy titled, "Management of Skin Rashes, Lesions and Irritations Guidelines", required registered nursing staff to include interventions that support a resident's altered skin integrity in the care plan. The care plan did not include the wound care intervention in place for resident #001. Registered nursing staff acknowledged that the interventions should have been added to the care plan, as this is where nursing staff identify wound care interventions in place for a resident.

Failure to add the intervention to the care plan may have led to staff being unaware of wound care interventions in place for resident #001 and any related direction for implementing them.

Sources: Resident #001 clinical record, Policy "Wound Care Management Policy" Appendix 8: Management of Skin Rashes, Lesions and Irritations Guidelines (reviewed March 2023), interviews with

staff. [740735]

B) An allied health provider recommended an intervention to assist with resident #004's wound healing. Documentation also indicated that registered staff applied a separate wound care intervention for pressure and pain relief related to the resident's wounds. A review of the resident's clinical record and interview with registered nursing staff confirmed that the wound care interventions were not listed in the care plan, where registered staff identify wound care interventions in place for a resident. The home's wound care management policy required registered staff to include interventions that support a resident's altered skin integrity in the care plan.

Failure to add the intervention to the care plan may have led to staff being unaware of wound care interventions in place for resident #004 and any related direction for implementing them.

Sources: Resident #004 clinical record, Policy "Wound Care Management Policy" Appendix 8: Management of Skin Rashes, Lesions and Irritations Guidelines (reviewed March 2023), interview with RPN #111. [740735]

WRITTEN NOTIFICATION: Skin and Wound Care - Wound Assessment

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument designed for skin and wound assessment.

Rationale and Summary
A) Documentation on an identified date indicated that registered nursing staff identified an area of altered skin integrity. An initial assessment of the wound should have been completed and was not, as indicated by a review of the resident's clinical record and an interview with registered nursing staff.

Failure to complete a skin assessment using a clinically appropriate assessment instrument when it was indicated increased the risk of worsening skin integrity.

Sources: Resident clinical record, interview with registered nursing staff. [740735]

B) A resident was readmitted to the LTCH on an identified date, and their admission skin assessment

indicated they had several areas of altered skin integrity. The assessment did not contain a description of each wound and there were no other initial wound assessments completed for the identified wounds. The Director of Care (DOC) indicated that the skin assessment did not contain details related to each wound, therefore it was not considered a complete initial wound assessment.

By not completing a skin assessment in full, registered staff may not have had complete data for comparing wound progression at the weekly wound reassessment.

Sources: Resident clinical record, interview with DOC. [740735]

WRITTEN NOTIFICATION: Police Notification

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service was immediately notified of a suspected incident of sexual abuse of a resident that may have constituted a criminal offence.

Rationale and Summary
On an identified date, a staff member witnessed another staff member in a sexual encounter with a resident. The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" stated that management will promptly and objectively report all incidents to external authorities, including the police if there are reasons to believe a criminal code offence has been committed. The Administrator acknowledged that the police were not notified about this incident.

Failure to immediately report the sexual abuse to the police resulted in potential risk to residents due to lack of police investigation.

Sources: Resident clinical records, Policy "Zero Tolerance for Resident Abuse and Neglect: Response and Reporting" (reviewed January 2022), interviews with staff and Administrator. [740732]

WRITTEN NOTIFICATION: Hiring Staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (2) (b)

The licensee has failed to ensure that a vulnerable sector check (VSC) was conducted within six months

before two identified staff members were hired.

Rationale and Summary
Two identified staff members started in the home during the summer of 2023. Both staff members provided a receipt of purchase for a VSC, but failed to provide the home with a VSC that was conducted before being hired by the home. The Administrator confirmed that the two staff had not provided a VSC prior to being hired.

Not ensuring that staff had a VSC prior to being hired placed residents at potential risk of harm.

Sources: Records for two identified staff members, interview with Administrator. [740732]

WRITTEN NOTIFICATION: Screening Measures

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 254 (4)

The licensee has failed to ensure that a VSC was provided by a staff member within three months of being hired.

Rationale and Summary
A staff member started at the home during the summer of 2022 and did not provide the home with a VSC within three months of being hired as per pandemic exceptions. The Administrator acknowledged that the staff member did not provide a VSC.

Not ensuring that this staff member had a VSC completed placed residents at risk.

Sources: Records for identified staff member, interview with Administrator. [740732]

COMPLIANCE ORDER CO #001 Skin and Wound Care - Wound Treatment

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:
The licensee shall prepare, submit and implement a plan to ensure the physician or nurse practitioner (NP) is notified by a member of the home's registered nursing staff when a resident presents with signs or symptoms of a deteriorating wound, to inform their treatment decisions.

The plan must include, but is not limited to:

1. Development and implementation of a wound care protocol which details:
    1. Directions on communicating signs of a deteriorating wound, including indicators of infection, to the physician or NP; and
    2. The home's expectation for documenting communication with the physician or NP in a resident's plan of care.
2. Training of all registered nursing staff on the protocol, including who will complete the training, when it will be completed and how it will be documented for the LTC Inspector to review.
3. The type of auditing that will be completed to evaluate implementation of the protocol, including who will be responsible for auditing, when it will be completed and how documentation will be maintained for the LTC Inspector to review.
4. Actions to be taken to ensure implementation of the protocol once the home has completed the training and audits.

Please submit the written plan for achieving compliance for inspection #2023-1220-0003 to Sydney Withers (740735), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by November 2, 2023. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that residents #001 and #004 who demonstrated altered skin integrity, including wounds, received immediate treatment to promote healing and prevent infection.

Rationale and Summary
A) Resident #004’s wound had an infection. The following day, registered nursing staff obtained a swab from the wound. The microbiology report was received one week later, indicating that there was an infection present, and the Medical Director (MD) was informed of the results. There were no orders written by the MD in response to the results.

The week the microbiology report was received by the home, the resident was assessed by an external

wound care specialist and no new treatments were ordered. The MD was contacted a second time with the culture results, and the registered nursing staff were directed to forward the results to the specialist's office. Staff documented that they contacted the specialist's office directly with the results. There were no changes to the resident's plan of care following this communication.

At a later time, the MD was contacted to assess the resident's wound as it had further deteriorated. Upon assessing the resident that same day, the MD performed a procedure on the wound and the treatment administration record (TAR) was updated with a new treatment order to clean and dress the wound.

Following the procedure by the MD, the resident visited the external wound care specialist, and an order was written for antibiotics to be taken over a several week period. A few days later, the resident was transferred to the hospital with a primary diagnosis of sepsis. The resident passed away while in the hospital.

The MD acknowledged that treatment of resident #004's wound was not immediate.

Failure to immediately treat the wound when there were signs and symptoms of infection resulted in a negative outcome for resident #004.

Sources: Resident #004 clinical record, hospital records, microbiology report, interviews with staff and MD. [740735]

B) On an identified date, resident #001 received updated wound care orders from a wound care specialist. The new orders were not entered into the TAR and administered by registered staff for one week. Appendix 8 of the home's "Wound Care Management" policy titled "Management of Skin Rashes, Lesions and Irritations Guidelines", directed registered staff to obtain orders for treatment and enter the orders into the TAR. Registered nursing staff acknowledged that the updated treatment order should have been entered into the TAR immediately.

Failure to enter the updated order into the TAR resulted in delayed treatment of the wound as ordered by the wound care specialist.

Sources: Resident #001 clinical record, Policy "Wound Care Management Policy" Appendix 8: Management of Skin Rashes, Lesions and Irritations Guidelines (reviewed March 2023), interviews with staff. [740735]

C) Resident #001 returned to the LTCH with a surgical wound on an identified date without treatment

orders for the wound. The TAR was revised with a new treatment order for the surgical wound 29 days following their return to the LTCH. The home's wound care management policy directed registered staff to obtain orders for treatment and enter the orders into the TAR. The DOC acknowledged that an order for treatment of the surgical wound should have been obtained and put in place immediately after the resident returned to the LTCH.

Failure to obtain a treatment order for the new surgical wound increased the risk of infection and delayed wound healing.

Sources: Resident #001 clinical record, Policy "Wound Care Management Policy" Appendix 8: Management of Skin Rashes, Lesions and Irritations Guidelines (reviewed March 2023), interviews with staff and DOC. [740735]

D) Resident #004's admission skin assessment indicated they had multiple areas of altered integrity, including wounds. Documentation indicated registered nursing staff received a treatment order for the resident's wounds from the MD; however, it was not added to the TAR. The home's wound care management policy directed registered staff to enter orders for treatment of a resident's wound into the TAR. Registered nursing staff acknowledged that the treatment order should have been entered into the TAR to prompt staff to complete the treatment.

Failure to enter the order into the TAR resulted in delayed treatment of the wound as advised by the MD.

Sources: Resident #004 clinical record, Policy "Wound Care Management Policy" Appendix 8: Management of Skin Rashes, Lesions and Irritations Guidelines (reviewed March 2023), interview with registered nursing staff. [740735]

E) Resident #004's admission skin assessment indicated they had a pressure injury. Treatment for the pressure injury was entered into the TAR one week following their admission. Registered nursing staff recalled the pressure injury and indicated they were not aware of it until the treatment order was entered. The home's wound care management policy directed registered staff to obtain orders for treatment and enter the orders into the TAR. Registered nursing staff acknowledged that the treatment should have been entered immediately when the pressure injury was identified upon admission.

Failure to obtain and enter a treatment order into the TAR for a pressure injury increased the risk of delayed healing and led to lack of awareness of the resident's altered skin integrity among staff.

Sources: Resident #004 clinical record, Policy "Wound Care Management Policy" Appendix 8:

Management of Skin Rashes, Lesions and Irritations Guidelines (reviewed March 2023), interview with registered nursing staff. [740735]

F) Resident #004's admission skin assessment indicated they had multiple areas of altered skin integrity. Treatment for these areas was entered into the TAR one week following their admission. Registered nursing staff acknowledged that a treatment order should have been obtained and entered into the TAR immediately when the altered skin integrity was identified.

Failure to obtain and enter a treatment order into the TAR led to a potential delay in treatment of the resident's altered skin integrity.

Sources: Resident #004 clinical record, Policy "Wound Care Management Policy" Appendix 8: Management of Skin Rashes, Lesions and Irritations Guidelines (reviewed March 2023), interview with registered nursing staff. [740735]

This order must be complied with by
November 30, 2023

COMPLIANCE ORDER CO #002 Skin and Wound Care - Wound Reassessment

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Re-educate all registered nursing staff on the process for completing weekly wound reassessments when clinically indicated, including how to enter an order for weekly wound reassessment in residents' administration records.
2. Maintain a record of the education, including the names of staff who completed it, the date and time it was completed and by whom.
3. Select four residents with altered skin integrity and perform weekly audits either for four weeks or until areas of altered skin integrity are resolved, to ensure completion of weekly wound reassessments.

4. Document the audits, including the names of staff who completed each audit, the names of the residents who were selected, the outcome of the audit and any corrective actions taken.

Grounds
The licensee has failed to ensure that resident #001 and #004's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A) Resident #001 had an order for weekly reassessment of impaired skin integrity to be completed on a specified day each week. A two-month period was selected to review completion of weekly skin reassessments based on when the resident's wounds began deteriorating. There were three weeks of missed skin reassessments, which was confirmed in an interview with registered nursing staff.

Failure to ensure resident #001's altered skin integrity was reassessed at least weekly may have resulted in delayed detection of infection and deterioration of their wounds.

Sources: Resident #001 clinical record, interview with registered nursing staff. [740735]

B) Resident #004’s admission skin assessment indicated multiple areas of altered skin integrity. Seven weekly wound assessments for various areas of altered skin integrity were not completed, which was confirmed by registered nursing staff.

Failure to ensure resident #004's altered skin integrity was reassessed at least weekly increased the risk of changes in their wounds not being identified.

Sources: Resident #004 clinical record, interviews with registered nursing staff. [740735]

C) Resident #004 was readmitted to the LTCH and their readmission skin assessment indicated they had multiple areas of altered skin integrity. There were 21 missed weekly wound reassessments for their various areas of altered skin integrity within an approximately two-month period. One area of altered skin integrity was not reassessed for three consecutive weeks. The DOC indicated if the weekly wound assessments were not located in the areas of the resident’s medical record reviewed by the inspector, they were not completed.

Failure to ensure resident #004's altered skin integrity was consistently reassessed at least weekly may have contributed to delayed detection of infection and deterioration of their wounds.

Sources: Resident #004 clinical record, interviews with staff and DOC. [740735]

This order must be complied with by
November 30, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.