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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 15, 2016	2016_216144_0073	022385-16, 027155-16, 028486-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

ILER LODGE
111 ILER AVENUE ESSEX ON N8M 1T6

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

CAROLEE MILLINER (144)

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): September 30, 2016 and October 3, and 7, 2016

The following infoline reports and complaint intakes were completed within this review:
- Infoline IL-45739-LO/022385-16 related to plan of care, nursing and personal support services and duty to protect,
- Infoline IL-46326-LO/ 027155-16 related to continence care and bowel management and responsive behaviours
- Complaint 028486-16 related to information and referral assistance, duty to protect, administration of drugs, responsive behaviours, menu planning and plan of care

During the course of the inspection, the inspector(s) spoke with one family member, the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), the Nutrition Manager (NM), two Registered Practical Nurses (RPN's), four Personal Support Workers (PSW's) and one Food Service Worker (FSW).

During the course of the inspection, the Inspector reviewed four resident clinical records, observed one resident and two PSW's scheduled the one to one staffing shift.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

One identified resident was admitted to the home with individualized dietary orders.

Review of the resident's clinical record revealed the initial plan of care included that the resident was to receive a specific food item with one meal per day. The resident's dietary profile was updated and included the specific food item and identified the meal the item would be served with.

Further review of the resident's clinical record revealed that on two occasions between August and September, 2016, staff did not provide the resident with the food item. The progress notes for both incidents indicated that the NM was aware of and had addressed the incidents.

Interview with one FSW confirmed their knowledge that the resident's dietary profile included a specific food item and identified when the food item would be served. The FSW added they did not plate the food item on one identified date as they did not read the resident's dietary profile thoroughly. The FSW added that as they started to warm the item, the resident became upset and left the dining room.

One PSW when interviewed stated that on a second identified date, they had forgotten the resident was to receive the specific food item and as they were ordering it, the resident became upset and left the dining room.

Two RPN's, two PSW's and the NM confirmed the resident's dietary profile was correct and that a sign had been previously placed in the dining room as a reminder to staff about the specific food item that was to be served to the resident.

A written letter of complaint was provided to the Administrator from the Substitute Decision Maker (SDM) and identified that the SDM met with the NM and Registered Dietician on a specific date at which time it was decided that the specific food item would be served to the resident and when it would be served.

The Administrator's written response to the SDM provided an apology that staff were not aware the resident was to receive the food item on one specific date and for the fact that this had been an ongoing issue.

The DOC confirmed by telephone that staff had forgotten the resident's food item on both identified dates and that the item was warmed immediately for the resident.

The DOC and NM shared that a sign had been previously posted in the dining room as a reminder to staff that the resident received the food item with one meal each day and that the food item was included in the resident's dietary profile or plan of care and should have been provided to the resident as planned. [s. 6. (7)]

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 care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 17th day of November, 2016

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

Original report signed by the inspector.