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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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
Mar 3, 2017	2017_538144_0002	029299-16, 030955-16, 033132-16, 033573-16, 034941-16	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 4, 5, 6, 2017

The following critical incident reports were reviewed with this inspection:
2129-000032-16 related to prevention of abuse and neglect
2129-000035-16 related to prevention of abuse and neglect
2129-000037-16 related to prevention of abuse and neglect
2129-000041-16 related to prevention of abuse and neglect
2129-000043-16 related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), two Registered Nurses (RN), three Registered Practical Nurses (RPN) and six Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed the home's abuse policy, observed resident to resident interactions and reviewed five resident clinical records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

Three critical incident reports were reviewed with this inspection.

Clinical record review for two identified residents stated that:
- both residents resided on the same resident home area and ambulated independently
- one of the identified residents was observed by one Activation Aide on one specific date and by three PSW's on two different dates, acting inappropriately toward a second identified resident
- one RPN, one PSW and one RN acknowledged the dates that one of the identified residents was referred to two different resident support teams
- the same RPN, PSW and RN also acknowledged the interventions that were initiated for one of the identified residents in response to the witnessed incidents with the second identified resident
- there were no further incidents between the two identified residents during the period of review by the Inspector.

The Executive Director and ADOC acknowledged that despite the interventions that were initiated to prevent recurrence in response to one resident's inappropriate manner toward a second resident, the inappropriate behaviour recurred on two alternate dates.

The severity of this issue was determined to be level 3 as there was actual harm/risk.
The scope of this issue was a pattern during the course of this inspection.
The home has a history of non-compliance with this section of the legislation as it was previously issued as Compliance Order (CO) #001 with the October 17, 2016, Resident Quality Inspection. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care based on an interdisciplinary assessment of the resident included any identified responsive behaviours and potential behavioural triggers and variations in resident functioning at different times of the day.

Three critical incident reports were reviewed with this inspection.

Review of the clinical records for the identified residents stated that:
- both residents resided on the same resident home area and ambulated independently
- one identified resident was observed by one RN on one specific date, one Activation Aide on an alternate date and three PSW's on two different dates, acting in an inappropriate manner toward a second resident.

One RPN, one PSW and one RN acknowledged the dates that one of the identified residents was referred to two different support teams; the same RPN, PSW and RN also acknowledged the interventions that were initiated for the resident in response to the witnessed incidents with the second identified resident.

The ADOC said that the internal support teams white board mounted in the conference room on one resident home area, was not updated with one resident's triggered responses until after the third incident of inappropriateness toward a second resident occurred. The update included interventions for staff to monitor the resident for increased identified behaviours.

Five PSW's acknowledged they referred to the support teams whiteboard for updates related to behaviour interventions for residents that resided on the resident home area.

The clinical record review for one identified resident stated that the plan of care was not

revised to include the identified behaviours toward a second resident after the first and second incident occurred. The clinical record further stated the plan of care for the resident was revised after the third incident to include monitoring of the resident for increased inappropriate behaviours.

The DOC acknowledged that the care plan for one identified resident was not revised until after the third incident to include monitoring for increased inappropriate behaviours.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was here was no history of non-compliance with this section of the regulation. [s. 26. (3) 5.]

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 responsive behaviour plan of care based on an interdisciplinary assessment of the resident included any identified responsive behaviours any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Three critical incident reports were reviewed with this inspection.

One RPN, one PSW and one RN from two different resident support teams acknowledged that in response to the first and second incidents, interventions were implemented on all shifts to prevent recurrence of the inappropriate behaviours from one identified resident toward a second identified resident.

The intervention documentation forms were reviewed for one resident for the day and evening shifts during a specific time period. The forms stated that nursing personnel had not documented their interventions on 39 per cent of the evening shifts and 47 per cent of the night shifts.

Three PSW's told the Inspector that a nursing staff member was not assigned to monitor one identified resident, that the resident was monitored by all staff working the unit. Four PSW's acknowledged the interventions were to be documented on the form provided and that a specific staff had not been assigned to complete that task.

One RPN stated they were not aware of the frequency of monitoring for one identified resident but was aware the intervention had to be documented on the form provided.

The ADOC and DOC acknowledged that it was their expectation that until further direction was given, nursing personnel documented their observations of one identified resident on the forms provided.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection.
There was no history of non-compliance with this section of the regulation. [s. 6. (9) 1.]

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

Issued on this 24th day of March, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLEE MILLINER (144)
Inspection No. / No de l'inspection :	2017_538144_0002
Log No. / Registre no:	029299-16, 030955-16, 033132-16, 033573-16, 034941-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 3, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT,8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	ILER LODGE 111 ILER AVENUE, ESSEX, ON, N8M-1T6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Desjarlais-Tefft

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure compliance with LTCA, 2007, S.O. c. 8, s.19(1) by ensuring that all residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

The licensee will initiate strategies to protect the health, safety and wellbeing of resident #004 and all other residents who may be exposed to untoward responsive behaviours while in the care of the long term care home.

This includes, but is not limited to:
1. Developing and implementing interventions in response to the resident demonstrating responsive behaviours.
2. Ensuring that interventions are implemented to prevent recurrence and minimize harm to residents.
3. Reviewing and revising the plan of care for resident #004 to ensure that assessments are integrated and are consistent and complement each other.
4. Ensuring that interventions that are implemented are monitored and evaluated.

The licensee will also ensure that all staff are re-educated on responsive behaviours.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

Critical incident reports #'s 2129-000037-16, 2129-000041-14 and 2129-000043 -16 on review stated that one resident was observed by personnel being

inappropriate with a second resident.

Clinical record review for residents #001 and #004 stated that:
- both residents resided on the secured James Brien unit on the first floor of the home and ambulated independently
- one of the identified residents was observed by one Activation Aide on one specific date and by three PSW's on two different dates, acting inappropriately toward a second resident
- one RPN and one PSW #103 from an external support team and one RN from an internal support team acknowledged the dates that one of the residents was referred to the internal and external support teams; the identified RPN, PSW and RN also acklowledged the interventions that were initiated for the identified resident in response to the witnessed incidents with the second resident
- there were no further incidents between the two identified residents during the period of review by the Inspector.

The Executive Director and ADOC acknowledged that despite the interventions that were initiated to prevent recurrence in response to one resident's inappropriate manner toward a second resident on one specific date, the inappropriate behaviour recurred on two alternate dates.

The severity of this issue was determined to be a level 3 as there was actual harm/risk. The scope of this issue was a pattern during the course of this inspection.
The home has a history of non-compliance with this section of the legislation as it was previously issued as Compliance Order (CO) #001 with the October 16, 2016 Resident Quality Inspection.

(144)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 17, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROLEE MILLINER

Service Area Office /
Bureau régional de services : London Service Area Office