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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 27, 2018	2018_729615_0020	013726-16, 028593-16, 035102-16, 000171-17, 020280-17, 020406-17, 021185-17, 022911-17, 023331-17, 024020-17, 025281-17, 025568-17, 026413-17, 027243-17, 027853-17, 004253-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

HELENE DESABRAIS (615), ALICIA MARLATT (590), CAROLEE MILLINER (144), CASSANDRA TAYLOR (725), NANCY SINCLAIR (537)

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): May 21, 22, 23, 24, 25, 28, 29, 30, 31 and June 1, 2018.

The following Critical Incident (CI) reports inspection were conducted:

CI #2129-000010-16/Log #013726-16 related to staff to resident alleged abuse;
CI #2129-000030-16/Log #028593-16 related to staff to resident alleged abuse;
CI #2129-000044-16/Log #035102-16 related to staff to resident alleged abuse;
CI #2129-000001-17/Log #000171-17 related to staff to resident alleged abuse;
CI #2129-000037-17/Log #020406-17 related to staff to resident alleged improper care;

CI #2129-000046-17/Log #021185-17 related to resident to resident alleged abuse;
CI #2129-000050-17/Log #023331-17 related to resident to resident alleged abuse;
CI #2129-000053-17/Log #025281-17 related to resident to resident alleged abuse;
CI #2129-000055-17/Log #025568-17 related to resident to resident alleged abuse;
CI #2129-000057-17/Log #026413-17 related to resident to resident alleged abuse;
CI #2129-000058-17/Log #027243-17 related to resident to resident alleged abuse;
CI #2129-000006-18/Log #004253-18 related to resident to resident alleged abuse;

CI #2129-000034-17/Log #020280-17 related to prevention of falls;

CI #2129-000047-17/Log #022911-17 related to safe and secure home;
CI #2129-000052-17/Log #024020-17 related to safe and secure home;
CI #2129-000060-17/Log #027853-17 related to safe and secure home.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6(1)(c) and 6(7) was identified in this inspection and has been issued in Inspection Report 2018_729615_0019, dated June 25, 2018, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), one Recreation Manager (RM), one Environmental Services Manager (ESM), three Registered Nurses (RNs), one Registered Dietician (RD), one Registered Practical Nurse-Resident Assessment Instrument Co-ordinator (RPN-RAI-Co-ordinator), four Registered Practical Nurses (RPNs), one Physiotherapist (PT), one Physiotherapist Assistant (PTA), one Housekeeping Aide, three Nurses Aides and 11 Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) also observed resident and staff interactions, reviewed medical records and plans of care for identified residents, reviewed relevant policies and procedures of the home and internal investigation notes, the home's weekly Outside Gait Security Check List and other relevant documentation.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy that promoted zero tolerance of abuse

and neglect of residents was complied with.

Section 2 (1) of the Ontario Regulation 79/10 defines “sexual abuse” as, (a) subject to subsection (3), 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, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; (“mauvais traitement d’ordre sexuel”)".

On a specific date, the home submitted a CI report to the MOHLTC related to resident to resident alleged sexual abuse.

A review of the Home's policy #ADMIN-O10.01 "Mandatory Reporting of Resident Abuse or Neglect" reviewed March 31, 2018, stated in part "Where any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person immediately verbally report the suspicion and the information upon which it is based to the person in charge (i.e. the nurse on duty ("the Nurse")). They will then together immediately report this to their legislative Authority as per legislation. (Ont - Director of the MOHLTC in accordance with Critical Incident Reporting Requirements). Following this, the Nurse will document the suspicion in the chart or each resident involved: Confirmed abuse or neglect of Residents will always be considered, at minimum, a serious adverse event and must be reported by staff following the Adverse Events Reporting Algorithm".

A review of the CI report revealed that on a specific date, three PSWs observed a resident allegedly abusing another resident and that the incident was not reported to management personnel until a later date.

During an interview, the ED acknowledged that the incident should have been reported immediately to the nurse in charge and that PSW staff did not follow the home's policy related to Mandatory Reporting of Resident Abuse or Neglect. [s. 20. (1)]

2. On a specific date, the home submitted a CI report to the MOHLTC related to alleged verbal abuse of a staff to a resident that occurred on a earlier date.

Section 2 (1) of the Ontario Regulation 79/10 defines “verbal abuse” as "(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of

well-being, dignity or self-worth, that is made by anyone other than a resident, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences".

During interviews, the RM, the RPN/RAI Co-ordinator and the HA, all stated that if they suspected abuse of a resident, they would report it to their respective supervisor.

During an interview, the ED and the DOC stated that the incident happened on a earlier date, that it was abuse and that the home's expectation would be that staff reported the alleged abuse immediately to the charge nurse and then to the MOHLTC. [s. 20. (1)]

3. On a specific date, the home submitted a CI report to the MOHLTC related to staff to resident alleged physical abuse that occurred on a earlier date.

Section 2 (1) of the Ontario Regulation 79/10 defines “physical abuse” means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitement d’ordre physique”).

A review of the CI report stated that a resident's family member reported to a staff member on earlier date suspicion of physical abuse of a resident.

A review of resident's progress notes in Point Click Care (PCC) on the earlier date stated that the resident's family member asked a staff member if the resident had been physically abused by staff. The staff member reported the family member's concerns immediately to a Registered Nurse.

During interviews, the RM, the RPN/RAI Co-ordinator and the HA, all stated that if they suspected abuse of a resident, they would report it to their respective supervisor.

During an interview, the ED and the DOC stated that the incident happened on a earlier date, that it was abuse and that the home's expectation would be that staff reported the alleged abuse immediately to the charge nurse and then to the MOHLTC. [s. 20. (1)]

4. On specific date, the home submitted a CI report to the MOHLTC related to staff physical abuse towards two residents that occurred on an earlier date.

A review of the CI report stated that on an earlier date, a staff member witnessed another staff member physically abusing the two residents. The staff member reported the alleged abuse to the ED only days later.

During interviews, the RM, the RPN/RAI Co-ordinator and the HA, all stated that if they suspected abuse of a resident, they would have reported it to their respective supervisor.

During an interview, the ED and the DOC stated that the incident occurred on an earlier date and that it was abuse and that the home's expectation would be that staff reported the alleged abuse immediately to the charge nurse and then to the MOHLTC.

The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

On a specific date the home submitted a CI report to the MOHLTC related to resident to resident alleged abuse that occurred on an earlier date. The CI report documented that the MOHLTC after hours pager was not contacted about this incident.

A review of the home's policy index ADMIN-O10.01 "Mandatory Reporting of Resident Abuse or Neglect", and last reviewed on March 31, 2018, stated that: "Where any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person must immediately verbally report the suspicion and the information upon which it is based to the person in charge (.i.e. the nurse on duty (the "Nurse")). The Nurse will then together immediately report this to their legislative Authority as per

legislation. (Ont – Director of the MOHLTC in accordance with Critical Incident Reporting Requirements)". The policy further stated that: "Ontario Specific: Mandatory reporting under the LTCHA (Ontario): Section 24(1) requires a person to make an immediate report to the Director of the Ministry of Health and Long Term Care is there is a reasonable suspicion that abuse or neglect occurred or may occur as well as the details to support the suspicion. This would apply to any of the following:
- Improper or incompetent treatment or care of a Resident that resulted in harm or a risk of harm to the Resident
- Abuse of a Resident by anyone or neglect of a Resident by the licensee or staff that resulted in harm or a risk of harm to the Resident
- Unlawful conduct that resulted in harm or a risk of harm to a Resident".

A review of the CI report, both resident's progress notes and a Risk Management report, all documented that a resident alleged that the other resident had been physically abusive when staff entered the room. The resident's progress notes documented that the resident was injured.

A review of the Risk Management home's report, indicated that the Director of the MOHLTC was not documented as one of the persons notified of the incident.

During an interview a RN shared that altercations between residents were reported to the managers of the home, both resident's Substitute Decision Maker's (SDM's) if applicable, and the physician as soon as possible, however did not mention reporting incidents to the MOHLTC after hours.

During an interview, the DOC who submitted the CI report, said that the incident took place on an earlier date and they completed the CI report at a later date. The DOC stated when asked, that the nurse should have contacted the after hours number for the MOHLTC to report the incident and had not done that. The DOC shared that the previous DOC completed all the reporting and none of the nurses ever called the after hours reporting number and that they had been educated to do so now.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

On a specific date the home submitted a CI report to the MOHLTC related to resident to resident alleged abuse that occurred on an earlier date.

A review of the home's policy index ADMIN-O10-02 "LTC – Investigation of Abuse or Neglect" last reviewed on July 31, 2016 stated that: "If the safety and security of a Resident or others are in jeopardy, the police shall be immediately contacted by dialing "911"."

A review of the CI report, both resident's progress notes and the Risk Management home's report, all documented that a resident alleged that the other resident had been physically abusive when staff entered the room. The resident's progress notes documented that the resident was injured. Neither of the documents identified that the police had been called and notified of the incident.

During an interview, a RN stated that the police were called when a resident was injured after an altercation, if any agitated residents involved could not be settled and the safety of other residents was at jeopardy.

During an interview, the DOC who submitted the CI report, said that the police should have been called for this incident and had not been.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence. [s. 98.]

Issued on this 27th day of June, 2018

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

Original report signed by the inspector.