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 prévue 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 Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 25, 2019 | 2019_563670_0005 | 025001-18, 025390-18, 026884-18, 031186-18, 033409-18 | 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

DEBRA CHURCHER (670), CASSANDRA TAYLOR (725)

## 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): Feruary 14, 19, 20 and 21, 2019.**

**The following intakes were inspected during this inspection:**

**Log# 025001-18 CIS# 2129-000028-18 related to alleged resident to resident abuse and responsive behaviors.**
**Log# 025390-18 CIS# 2129-000029-18 related to alleged resident to resident abuse and responsive behaviors.**
**Log# 025001-18 CIS# 2129-000028-18 related to alleged resident to resident abuse and responsive behaviors.**
**Log# 031186-18 CIS# 2129-000040-18 related to alleged resident to resident abuse and responsive behaviors.**
**Log# 026884-18 CIS# 2129-000032-18 related to a fall with injury.**
**Log# 033409-18 CIS# 2129-000046-18 related to a fall with injury.**

**During the course of the inspection, the inspector(s) spoke with spoke with the Administrator, the Director of Care, the Assistant Director of Care, two Registered Nurses, seven Personal Support Workers and two Health Care Aides.**

**During the course of this inspection the Inspectors observed the overall maintenance and cleanliness of the home, observed the provision of care and staff to resident interactions,**
**reviewed relevant clinical records and home policies and programs and completed relevant interviews with staff, families and residents.**

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

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**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.

The home called the Ministry of Health and Long-Term Care (MOHLTC) IL-60009-AH, and submitted a Critical Incident System (CIS) report describing an incident.

The CIS report indicated that there was a witnessed incident involving resident #007 and resident #005 that resulted in a specific injury.

During record review of progress notes in Point Click Care(PCC) for resident #007 it indicated that they had experienced a specific injury resulting in specific medical interventions.

During an interview with Assistant Director of Care (ADOC) # 114 and Director of Care #111 they acknowledged that there had been an incident that involved resident #007 and resident #005 and that the incident had resulted in an injury.

The licensee has failed to ensure that resident #007 was protected from abuse by anyone. [s. 19. (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 long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.***

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**Issued on this 25th day of February, 2019**

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

**Original report signed by the inspector.**