Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2020	2020_678590_0005	002153-20, 002345-20, 002505-20, 002936-20, 003308-20, 003542-20	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

ALICIA MARLATT (590), JULIE DALESSANDRO (739)

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): March 3 - 6 and 9, 2020.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Environmental Services Manager, one Registered Nurse, three Registered Practical Nurses, two Health Care Aids and six Personal Support Workers.

During the course of the inspection, the inspector(s) observed residents and their rooms for specific interventions to be in place, resident/resident and staff/resident interactions and infection prevention and control practices.

During the course of the inspection, the inspector(s) reviewed resident's clinical records, Critical Incident System reports, Risk Management reports, written procedures and policies related to inspection topics, email correspondence between the long-term care home and their corporate office and Arjo Canada, one Service Call Report and Service Provider Acknowledgement forms and Annual Education Declaration forms for contracted service providers.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door

A Critical Incident System report was submitted to the Ministry of Long-Term Care (MOLTC) on a specific day, to report the elopement of resident #001 from the long-term care homes secured unit. The home reported that resident #001 was able to exit the secured unit without any supervision. The resident proceeded to exit the building out the front door and was found a street over from the home by a pedestrian who contacted the police.

In an interview with Environmental Services Manager (ESM) #102 they shared that the home has had their external contracted company come and service the fire panel in the home. In the days prior to resident #001's elopement, the homes fire panel had been malfunctioning, causing the fire alarm to go off and the fire department to respond; it would alarm for false fires in the building. The ESM shared that the contracted company workers were able to fix the issue with the fire panel safely over the couple days, however when performing routine maintenance afterwards, they had accidentally and unknowingly deactivated the door magnetic lock system for a short period of time. It was during this time that resident #001 had eloped from the building. During the time periods when the fire panel was not working properly, the home was on 'fire watch' which consisted of designated staff members at the home completing a walk around of their units and common areas to monitor the building for fires every 15 minutes. The ESM shared that the doors were not monitored during the fire watch as it was not part of the regular fire watch process and they had not been made aware from the workers from the contract company that their work on the panel system may affect the door security in the home.

In an interview with ED #100 they shared that moving forward, when an external contracted company and their workers come to perform duties and service, the home will be aware that any system they are working on may malfunction at any time, and that they would have appropriate precautions in place for whichever system in the home needed maintenance. The ED stated that resident #001 was able to elope from the secured unit in the home when service was provided to the fire panel, and the door system was unbeknownst disengaged by the service providers during routine maintenance. [s. 9. (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 all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are:
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System report was submitted to the MOLTC on a specific day, reporting an incident of improper care of a resident. The home reported that resident #002 was transferred by one staff member, when two staff members should have been present. The resident sustained an injury that required sutures and antibiotic therapy, which was discovered at the time of the transfer.

Review of resident #002’s clinical record at the time of the injury was completed. It showed that resident #002 had a care plan that stated they were a two person transfer and that staff could also use the sit to stand mechanical lift to transfer the resident.

Observation of resident #002's room showed that there were two transfer logos present above the bed. One was a two person transfer logo and the other was a sit to stand mechanical lift logo dated before this transfer was performed.

In an interview with Registered Practical Nurse (RPN) #114, they shared that they were working at the time of resident #002's injury and that at two o'clock that afternoon the resident had a bath and did not have the injury. They said that the Personal Support Worker (PSW) who came and reported the injury to them later in the shift, demonstrated the transfer they completed with the resident to them, and that they had demonstrated a one person pivot transfer with the resident from the chair to the bed. The RPN shared that they examined the surrounding area for anything that may have injured the resident and found nothing alarming. The RPN shared that the residents transfer logo above the bed at the time was a two person transfer logo and a sit to stand mechanical lift logo.

In an interview with DOC #101 they shared that they investigated the incident and found that the PSW had disregarded the visual transfer logos kept above resident #002’s bed and was disciplined as a result. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 2nd day of June, 2020

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

Original report signed by the inspector.