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

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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
Jul 21, 2021	2021_790730_0024	007504-21, 009330-21, 009812-21	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

CHRISTINA LEGOUFFE (730), KRISTEN MURRAY (731)

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): July 7, 8, 9, 13, 14, and 15, 2021.

The following Critical Incident System (CIS) intakes were completed within this inspection:

CIS # 2129-000013-21/ Log # 007504-21 related to falls prevention
CIS # 2129-000016-21/ Log # 009330-21 related to prevention of abuse and neglect and nutrition and hydration
CIS # 2129-000018-21/ Log # 009812-21 related to prevention of abuse and neglect.

An Infection Prevention and Control (IPAC) inspection was also completed as part of this inspection.
A cooling and air temperature inspection was also completed as part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Executive Director (ED), a Housekeeper, a Screener, the Infection Prevention and Control (IPAC) Lead, the Environmental Service Manager (ESM), a Registered Dietitian (RD), the Behavioural Supports Ontario (BSO) lead, Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and residents.

The inspectors also observed resident rooms and common areas, observed meal service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the home's investigation notes, and reviewed the home's temperature records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
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)**
- **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 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 a resident was protected from physical abuse by a Personal Support Worker (PSW).

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by anyone other than a resident that causes physical injury or pain.”

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care related to an incident of staff to resident physical abuse.

A PSW stated that they went with another PSW to perform personal care on a resident and that the resident became physically resistive to the care provided. They said that the PSW restrained the resident while they performed care. A Registered Practical Nurse (RPN) said that after the incident, when they assessed the resident, they noted that the resident had obtained injuries.

A Revera document defined physical abuse as, “any deliberate act of violence or rough treatment of a Resident/client causing injury, bodily harm, pain, or discomfort. Use of physical force by anyone other than a resident that causes physical injury or pain.”

The RPN stated that the expectation in the home was that if a resident became resistive, that staff should ensure that the resident was safe, leave, and re approach the resident at a later time. They also said that staff were not permitted to restrain residents. The Director of Care (DOC) stated that the allegation of staff to resident abuse was substantiated during the home’s investigation and that action was taken against the staff member.

As a result of the incident, the resident sustained an injury.

Sources: Critical Incident Report, resident clinical record including progress notes, the home’s internal investigation notes, and interviews with an RPN and other staff. [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 residents are protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, and that temperatures were measured and documented at least once every morning, afternoon, and evening in one resident common area on every floor of the home.

A review of the home's temperature records for May, June and July 2021, identified that the home was not measuring and documenting in writing the temperatures in any resident bedrooms. The temperature records also identified that the home was not measuring and documenting the temperatures at least once every morning, afternoon and evening in one resident common area on each floor of the home.

In separate interviews with Environmental Service Manager (ESM) and the Director of Care (DOC), they confirmed the home was not measuring and documenting temperatures at least every morning, afternoon and evening, and no resident bedroom temperatures were being measured and documented.

Sources: The LTCH's temperature records; and interviews with the DOC and ESM. [s. 21.]

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 air temperature of the home is measured and documented in writing in at least two resident bedrooms in different parts of the home, and that temperatures are measured and documented at least once every morning, afternoon, and evening in one resident common area on every floor of the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE) for a resident.

During an observation an Inspector observed a Personal Support Worker (PSW) perform direct care on a resident. The PSW did not wear gloves while they provided care to the resident. Signage outside of the resident's door indicated that they were on contact precautions.

The home's policy titled "Contact Precautions" (Reviewed March 31, 2021), said that staff were to wear gloves when providing direct care to a resident on contact precautions.

The PSW said that staff used the signage posted outside of resident rooms to know if a resident was on additional precautions. They said that they should have worn gloves when providing care to the resident. The IPAC Lead said that the resident was currently on contact precautions and that the staff member should have worn gloves when providing care to the resident.

There was increased risk to residents when staff did not wear the appropriate PPE when they provided care to the resident.

Sources: Resident clinical record including progress notes and plan of care, observations, and interviews with the IPAC Lead and other staff. [s. 229. (4)]

Issued on this 22nd day of July, 2021

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

Original report signed by the inspector.