Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**London District**
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# Original Public Report

**Report Issue Date:** June 4, 2024

**Inspection Number:** 2024-1051-0002

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

**Long Term Care Home and City:** Iler Lodge, Essex

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6, 7, 8, 9, 10 & 13, 2024.

The following intake(s) were inspected:

- Intake: #00110585 - Follow-up to Compliance Order# 001 from inspection #2024_1051_0001. Compliance Due Date May 1, 2024. Related to condition of the home, furnishings and equipment being kept clean and sanitary.
- Intake: #00110587 - Follow-up to Compliance Order #003 from inspection

#2024_1051_0001. Compliance Due Date April 11, 2024. Related to immediate investigations of allegations of abuse or neglect.

- Intake: #00110588 - Follow-up for Compliance Order #004 from inspection #2024_1051_0001. Compliance Due Date April 11, 2024. Related to keeping written records of verbal and written complaints.
- Intake: #00110584 - Follow-up to Compliance Order #005 from inspection #2024_1051_0001. Compliance Due Date April 11, 2024. Related to immediate reporting to the Director.

- Intake: #00108615 - CI #2129-000014-24 Complaint Response – Alleged staff to resident neglect.
- Intake: #00109112 - CI #2129-000015-24 Alleged staff verbal abuse and neglect of resident.
- Intake: #00109320 - CI #2129-000017-24 Alleged staff to resident neglect.
- Intake: #00109535 - CI #2129-000019-24 Alleged staff improper/incompetent care of resident.
- Intake: #00110900 - CI #2129-000024-24 Fall of resident with injury.
- Intake: #00113046 - CI #2129-000030-24 Alleged resident to resident physical abuse.
- Intake: #00114877 - CI #2129-000033-24 Alleged staff to resident abuse, improper care.
- Intake: #00109234 - Complaint concerns regarding alleged neglect of a resident.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #005 from Inspection #2024-1051-0001 related to FLTCA, 2021, s. 28 (1) 2. inspected by Cassandra Taylor (725)

Order #003 from Inspection #2024-1051-0001 related to FLTCA, 2021, s. 27 (1) (a) (ii) inspected by Cassandra Taylor (725)

Order #004 from Inspection #2024-1051-0001 related to O. Reg. 246/22, s. 108 (2) inspected by Cassandra Taylor (725)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1051-0001 related to FLTCA, 2021, s. 19 (2) (a) inspected by Terri Daly (115)

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Palliative Care
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a staff member stayed with a resident while they were being assisted.

**Rationale and Summary**
A resident was being assisted by two staff when they left to assist another resident. When the staff returned, the resident was on the floor.

The resident's care plan indicated when assisting the resident maintain privacy but stay in immediate area.

During an interview with the Associate Director of Care (ADOC) they confirmed that the staff did not follow the resident's plan of care and should not have left the resident alone.

Not following the residents plan of care placed the resident at risk for a fall and potential injuries.

**Sources:** Resident's clinical records and staff interviews.
[725]

## WRITTEN NOTIFICATION: Accommodation Services - Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with order #001 from inspection #2024_1051_0001 with a compliance due date of May 1, 2024.

The licensee failed to comply with the following area of the order:
-implement a plan to maintain the home, furnishings and equipment and ensure they are kept clean and sanitary.

**Rationale and Summary:**
During observations in May 2024, while accompanied by managers within the home, there were multiple areas of concern with cleanliness in the kitchen, serveries, dining rooms, resident rooms, lounges and dens, nursing desks, spa rooms, and visitor bathrooms.

During interviews with the Executive Director (ED), the Regional Manager (RM), the Environmental Services Manager (ESM) and a housekeeping aide (HA), they all acknowledged that there were still areas that needed additional cleaning.

The home's failure to ensure that the home was kept clean and sanitary may increase the potential for risks associated with infectious diseases and potentially impacts the resident's right to live in a safe, clean environment in a dignified manner. [115]

**This Written Notification is being referred to the Director for further action by the Director.**

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Written Notification NC #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**
The licensee has failed to comply with order #001 from inspection #2024_1051_0001 with a compliance due date of May 1, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## WRITTEN NOTIFICATION: Policies and Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)**
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee failed to ensure that a staff member followed the home's policy relating to safe lifts and transfers.

**Rationale and Summary:**

During an internal investigation by the Long-Term Care Home (LTCH), it was determined that a staff member transferred a resident independently using a lift.

The home's policy titled, Safe Resident Handling - Operation of Mechanical Lifting/Transferring and Repositioning Devices. INDEX: CARE6-O10.07 – LTC effective August 31, 2016, stated in part; Two staff must be present while the mechanical device is in operation, and while the sling is being attached to the lift, to ensure safety and follow through of all procedures.

The Director of Care (DOC) indicated it would be the expectation for staff to follow safe transfers and ensuring two staff are using the lift to transfer residents.

Not having two staff present during transfers using lifts placed the resident at potential risk for injury.

**Sources:** a resident's clinical records, CI report, internal investigation notes and staff interview.
[725]

## WRITTEN NOTIFICATION: Use of Equipment

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 26**
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff used equipment in the home in accordance with the manufacturers' instructions.

**Rationale and Summary:**
A resident required the use of a lift for transfers. Investigation notes showed that a staff member admitted to leaving a resident alone attached to the lift.

The lift instructions for use indicated that the resident was not to have been left unattended.

The Director of Care (DOC), admitted that the resident was left alone attached to the lift and should not have been.

Not using the lift as per the manufacturer's instructions put the resident at risk for injury.

**Sources:** a resident's clinical record, lift instructions for use, and staff interviews. [670]