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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 6, 2015	2015_349590_0033	018124-15	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 27, 2015

This inspection was completed regarding resident rights.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Assistant Director of Care (ADOC), a Registered Nurse (RN) and one family member of a Resident.

During the course of the inspection, the inspector reviewed one resident's clinical record and one of the homes policies related to nutrition.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure they fully respected and promoted the right of the dying or very ill resident to have family and friends present 24 hours per day.

In an interview with Resident #001's Power of Attorney (POA) they revealed that a voice message was left indicating the resident's condition had changed and requested the family to come in. The POA was not at home to receive the message and it was not until later when they returned home that the message was received. The POA was leaving for the home when a phone call from the home was received indicating that the resident had just passed away. The POA had indicated to the inspector that after a discussion with the family, the home had failed to contact the other POA and another listed emergency contact of Resident #001's decline in condition.

In an interview with the ED and the ADOC they revealed that all the resident's contact's were documented and located in the computerized system called Point Click Care (PCC) and this was the system referred to by the registered staff to contact families of residents. They confirmed Resident #001 had one POA with a corresponding phone number listed as an emergency contact in the PCC system.

Review of Resident #001's paper documentation revealed that there were several documents - an admission profile, a resident/family questionnaire and a Community Care Access Centre (CCAC) evaluator questionnaire - which listed the numbers for two POA's for care and one other family member to contact in an emergency.

In an interview with the ED and the ADOC they confirmed that it was their expectation and the registered staff's responsibility to transcribe the admission information, including emergency contact names and numbers into the PCC system and that they had failed to do so. The home did not fully respect and promote this resident's rights to have friends and family present by omitting to notify all POA's and emergency contacts when the resident had a serious change in condition and was very ill. [s. 3. (1) 15.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

In an interview with Resident #001's POA they revealed that they were not made aware of the resident's decline and health concerns. The POA had inquired with the staff about the health concerns and was informed then, that Resident #001 was having difficulties eating and had poor oral intake for some time.

In June 2015, it was first documented by registered staff that Resident #001 had a decline in their ability to chew foods; the resident was on a special textured diet. In June 2015, the Registered Dietitian (RD) had made a progress note entry indicating that a referral was received from the registered staff indicating Resident #001 was having difficulties chewing foods. On that day a new diet texture was implemented. One week later another progress note entry by the RD had indicated the resident was tolerating the new diet texture poorly and initiated a nutritional supplement.

Review of the home's policy titled "Nutrition Care Referral" Index: LTC-G-50 last revised in October 2014, indicated in the National Operating Procedure that:

1. A hand written referral (LTC-G-50-05) or an electronic referral in Point Click Care (PCC) would be made to the Registered Dietitian (RD) with any significant change in the Resident's health affecting nutritional status.
2. The RD would make nutritional recommendations once an assessment and interview (if possible) with the Resident and/or his/her substitute decision maker (SDM) was completed.

3. All recommendations would be discussed with the Resident (if possible), the Resident's Family/Substitute Decision Maker (SDM) and the Interdisciplinary Team as required.
4. The RD would document any changes in the interdisciplinary progress notes and in the Resident's Care Plan. It was recommended to provide a summary of intervention changes to the Nutrition Manager (NM)/designate via RD and NM Communication Log LTC-G-10-15.

In an interview with the ADOC she shared that it was the homes expectation that the registered staff notify the Resident and (POA)/SDM of changes to care and treatments, including changes to diet textures. She confirmed that the home did not discuss Resident #001's decline in oral intake and changes to diet textures with this resident's POA as required by the homes policy. [s. 8. (1)]

Issued on this 11th day of August, 2015

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

Original report signed by the inspector.