Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 19, 2011	2011_144_2129_19Apr103844	L-000467 Critical Incident

Licensee/Titulaire
Revera Incorporated, 66 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/Nom de l'inspecteur
Carolee Milliner (#144)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to a resident fall.

During the course of the inspection, the inspector spoke with one resident, the Administrator, Director of care, one RN & one PSW.

During the course of the inspection, the inspector reviewed one resident clinical record and the relevant critical incident report.

The following Inspection Protocols were used in part or in whole during this inspection:
Falls.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA,2007,S.O.c.8,s.6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:
1. The plan of care for one resident does not provide clear directions to staff providing care related to a physician's treatment order. The physician medication & treatment review includes directives to monitor resident & provide treatment every 3 months. The written plan of care does not include goals & interventions related to monitoring & the ordered treatment.
2. The clinical record for one resident does not provide clear directions to staff and others who provide direct care related to transfer, toileting & mobility needs. The MDS quarterly assessment identifies resident requires assistance of one person to address the above identified needs. The written plan of care identifies resident requires assistance of one to two persons.
3. On the date of inspection, resident was observed exiting the washroom with a walker & without presence of staff. Resident confirmed to the Inspector, they toilet independently of staff assistance.

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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 related to the plan of care providing clear directions to staff providing care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA,2007,S.O.c.8,s6(10)(b)
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

Findings:
1. One resident experienced a fall resulting in initial soreness & complaints of discomfort requiring administration of non-narcotic analgesic medication & a questionable concussion. A pain assessment was not completed post fall in response to complaints of discomfort.

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WN #3: 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.

Findings:
1. Staff did not use safe technique when transferring one resident down the corridor on their wheeled walker.

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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 related to staff use of safe transferring techniques, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** April 21, 2011