



**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**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 20, 2016	2016_216144_0075	023972-16	Critical Incident System

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**Licensee/Titulaire de permis**

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

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**Long-Term Care Home/Foyer de soins de longue durée**

ILER LODGE  
111 ILER AVENUE ESSEX ON N8M 1T6

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

CAROLEE MILLINER (144)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): October 3, 2016**

**The following Intakes and Critical Incident reports were reviewed during this inspection.**

- Intake 023972-16, Critical Incident 2129-000020-16 related to responsive behaviours**
- Intake 023976-16, Critical Incident 2129-000022-16 related to responsive behaviours and duty to protect**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), two Registered Practical Nurses (RPN's) and five Personal Support Workers (PSW's).**

**During the course of the inspection, the Inspector reviewed four resident clinical records and observed three residents and two PSW's assigned to one to one staffing.**

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

**During the course of this inspection, Non-Compliances were issued.**

- 1 WN(s)**
- 1 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**

**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**

**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**

**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**



**Findings/Faits saillants :**

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

One resident was admitted to the home with various diagnosis including responsive behaviours.

Review of the resident's application for admission to the home revealed the resident had a history of responsive behaviours.

The initial progress note in the resident's clinical record outlined their diagnosis and known responsive behaviours.

Post admission this resident was witnessed by a PSW verbally intimidating a second resident. This resident then proceeded to another location where they displayed verbal and physically threatening behaviours toward the second resident

Review of the resident's clinical record revealed interventions related to the resident's history of responsive behaviours were not documented until after the above identified incident.

Critical Incident reports #2192-000020-16 and 2129-000022-16 included a statement by the author that interventions were not in place prior to this incident as the home was still assessing and evaluating the resident's behavioural patterns.

Interview with the DOC and three RPN's confirmed interventions to minimize the risk of altercations and potentially harmful interactions between this resident the and other residents, was not developed until after the above incident occurred. [s. 54. (b)]



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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 to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.***

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**Issued on this 24th day of October, 2016**

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

**Original report signed by the inspector.**