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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 27, 2018	2018_729615_0019	021949-17, 023117-17, 023120-17, 024742-17, 025235-17, 026242-17, 027876-17, 029096-17, 001249-18, 003601-18, 009252-18	Complaint

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

HELENE DESABRAIS (615), ALICIA MARLATT (590), CAROLEE MILLINER (144), CASSANDRA TAYLOR (725), NANCY SINCLAIR (537), TERRI DALY (115)

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): May 22, 23, 24, 25, 28, 29, 30, 31, and June 1, 2018.

The following Complaint reports inspections were conducted:

**Complaint #IL-52907-LO/Log #021949-17 related to staff to resident alleged abuse;
LTCH Complaint/Response related to staff to resident alleged abuse;
Complaint IL-55023-LO/Log #001249-18 related to staff to resident alleged abuse;
Complaint IL-56825-LO/IL-56861-LO/Log #009252-18 related to staff to resident alleged abuse;
Complaint IL-53274-LO/Log #023120-17 related to alleged neglect of a resident;
Complaint IL-54419-LO/Log #027876-17 related to alleged neglect of a resident;
Complaint IL-55592-LO / IL-56392-LO/Log #003601-18 related to alleged neglect of a resident;**

Complaint IL-54633-LO/Log #029096-17 related to prevention of falls;

**Complaint IL-53269-LO/IL-53378-LO/Log #023117-17 related to prevention of falls and plan of care not followed;
Complaint IL-53724-LO/Log #024742-17 related to plan of care not followed;
Complaint IL-53866-LO/Log #025235-17 related to plan of care not followed.**

The following intakes were completed during this Complaint Inspection:

**Critical Incident report #2129-000006-18/Log #004253-18 related to resident to resident alleged abuse;
Critical Incident report #2129-000046-17/Log #021185-17 related to resident to resident alleged abuse.**

PLEASE NOTE: A Written Notification and Voluntary Plan Correction related to LTCHA, 2007, c.8, s. 20(1), and a Written Notification related to LTCHA, 2007, c.8, s. 24(1) and Ontario Regulation 79/10, r. 98 was identified in this inspection and has been issued in Inspection Report 2018_729615_0020, dated June 25, 2018, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), one Recreation Manager (RM), one Environmental Services Manager (ESM), three Registered Nurses (RNs), one Registered Dietician (RD), one Registered Practical Nurse-Resident Assessment Instrument Co-ordinator (RPN-RAI-Co-ordinator), four Registered Practical Nurses (RPNs), one Physiotherapist (PT), one Physiotherapist Assistant (PTA), one

Housekeeping Aide, three Nurses Aides and 11 Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) also observed resident and staff interactions, reviewed medical records and plans of care for identified residents, reviewed relevant policies and procedures of the home and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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	
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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

On a specific date a Complaint report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in which a family member of a resident had made a complaint regarding a fall on a specific date, expressing concerns that staff were transferring a resident without following the care plan.

Two residents were identified as requiring staff support for transfers.

A review of the residents' care plan in Point Click Care (PCC) indicated that the residents required extensive assistance with transfers. The Safe Lift and Transfer (SALT) assessment indicated that the resident was to be transferred in the morning with two staff and with a device, in the evening with one or two staff and a device and in the night with one or two staff and a device.

During interviews, a PSW and a RPN stated that the SALT assessment would determine the resident's transfer status and that the transfer status information could be found in the residents' room, assessments, kardex and care plan.

During an interview, the DOC said that the care plan should match the SALT assessment and that the care plan did not give clear direction to staff for the transfer status of the residents. [s. 6. (1) (c)]

2. On a specific date, the home submitted a complaint/response report to the MOHLTC in follow up to a written complaint received from the family of a resident regarding care related concerns.

During interviews, the family of the resident stated that they had concerns over communication within the home as staff did not provide care in a consistent manner to the resident. The family member provided examples of care routines and transfer status.

Observation of the resident's room identified two documents identifying resident's care needs.The two documents and the car plan did not corroborate with each other.

During an interview, a PSW stated that the resident was transferred using specific devices, and the decision was based on assessment of the resident by staff at the time of the transfer.

During an interview, a PSW #113 stated that the resident was transferred using a specific device, based on the PSW’s assessment at the time of transfer. The PSW said that they would review the documentation of the resident's needs in their room for a reference to transfer status. The PSW also stated that the information could be found in the written plan of care that was accessed on the computer. The PSW stated that the written plan of care direction and the documentation posted in the resident room were not consistent.

During an interview, a RN stated that when a resident was assessed for care needs, the person who completed the assessment was responsible to ensure that all areas of the plan of care were updated and were consistent in all places.

During an interview, the DOC stated that the expectation would be that all areas where resident care related information was located would be consistent, including the transfer documentation in a resident room and the written plan of care so that care was completed in a consistent manner by all staff.

3. On a specific date, the home submitted a CI report to the MOHLTC describing an incident of a resident to resident alleged abuse.

Review of the homes policy titled “LTC – Dementia Care – Assessment and Care Planning”, index: CARE3-O10-01, and last reviewed on March 31, 2018, stated that “Monitoring of responsive behaviours will be completed using an objective systematic tracking tool such as the Dementia Observation System (DOS)".

A review of the resident's care plan stated that staff were to observe closely the behaviours of the resident using DOS monitoring.

A review of the resident's documentation showed that the monitoring took place for a specific time and that documentation was observed to be missing on the documents a specific day and time.

During an interview, two Nurses Aids said that when DOS documentation was required, they were to complete the documentation every shift as outlined on the form.

During an interview, a RPN stated that the DOS documentation was required to be completed as outlined on the form, but completion of the DOS documentation had been an ongoing issue. The completion of the DOS documentation was required, as the physician also liked to review the DOS documentation prior to adjusting medications for residents presenting behaviours. They shared that staff would be receiving education related to responsive behaviours documentation and monitoring soon.

During an interview,a RN said that documentation should be implemented when incidents occurred and should be completed every shift as outlined on the form.

During an interview, the DOC said that the documentation was not completed and should have been completed as outlined on the form and in the care plan. [s. 6. (1) (c)]

4. On a specific date the home submitted a CI report to the MOHLTC describing an incident of a resident to resident alleged abuse. The CI report documented that documentation was initiated after the incident involving the two identified residents to monitor for further behaviours.

A review of the resident's care plan stated that staff were to initiate documentation as needed.

A review of the resident's documentation showed that the monitoring took place for a specific time and that documentation was observed to be missing on the documents on three different days and time.

During an interview, two Nurses Aids stated that when documentation was required, they were to complete the documentation every shift as outlined on the form.

During an interview, the RPN stated that the documentation was required to be completed as outlined on the form, but completion of the documentation had been an ongoing issue. The completion of the documentation was required, as the physician also liked to review the documentation prior to adjusting medications for residents presenting behaviours. They shared that staff will be receiving education related to responsive behaviours documentation and monitoring soon.

During an interview, a RN said that the documentation should be implemented when incidents occurred and should be completed every shift as outlined on the form.

During an interview, the DOC said that the documentation on the form was not completed and should have been completed as outlined on the form.

The licensee has failed to ensure that he written plan of care for the residents provided clear direction to staff and others who provided care to a resident. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care for residents was provided as specified in the plan.

On a specific date, the home submitted a Complaint report to the MOHLTC from a resident’s family member observing that the assigned one to one staff member was not always present with a resident as required.

A review of the resident's progress notes for a specific time, there were three entries observed where the one to one staff was not present with a resident. On a specific date, the progress notes indicated that the one to one staff member was at the nursing station when an altercation occurred between two residents and did not see the altercation.

On a specific date, the progress notes indicated that the resident's family member came to visit and found the resident alone and that the one to one staff member had left the resident alone for a moment.

On a specific date, progress notes indicated that the DOC found the resident walking alone in front of their office. The note further indicated that the resident's family member was visiting and had approved of the one to one staff member to go and get refreshment for the resident.

A review of resident’s care plan stated, in the responsive behaviours section, that the resident was on one to one monitoring at all times, that staff were to be in the same room as the resident on days and evenings, and that the night shift staff was to sit directly outside of their room or in their room.

During an interview, two PSWs stated that when one to one care was provided to the resident they should ideally be within arm’s reach of the resident or no more than a couple feet away in case intervention was needed.

During an interview, the DOC said that the one to one staff member for the resident should have been present at all times and close by in case intervention was needed, and acknowledged that the identified times above where the one to one staff was not present, even for a moment of time, and should have been. [s. 6. (7)]

6. On a specific date, the family of a resident submitted a complaint report to the MOHLTC of concerns of a resident not being properly assessed and the plan of care not being followed regarding nutrition.

A review of the resident's care plan included a nutritional care focus and an intervention which stated that resident required a specific device.

On a specific date, the resident was observed in a common area not utilizing the specific device.

During an interview, a PSW stated that they were not aware for utilization of that specific device.

During an interview, the DOC stated that they were not aware that there had been an assessment completed that would include the use of a specific device and that they would expect that the care as outlined in the plan of care would be what was followed for all residents.

The licensee has failed to ensure that the care set out in the plan of care for residents was provided as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care provided to the resident as specified in the plan and to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident., to be implemented voluntarily.

Issued on this 28th day of June, 2018

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

Original report signed by the inspector.