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

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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
Oct 1, 2018	2018_563670_0021	003387-18	Resident Quality Inspection

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

DEBRA CHURCHER (670), ALICIA MARLATT (590), CASSANDRA TAYLOR (725), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 17, 18, 19, 20, 21, 24, 25, 26, 27 and 28, 2018.

During the course of this Resident Quality Inspection (RQI) the following complaints were inspected;
Log# 023884-18 Info Line# 59501-LO related to management staffing.

During the course of this inspection the following Critical Incident System (CIS) Reports were inspected;
Log# 017345-18 CIS# 2129-000020-18 related to alleged improper administration of medication.
Log# 008702-18 CIS# 2129-000012-18 related to responsive behaviors.
Log# 012150-18 CIS# 2129-000016-18 related to responsive behaviors.
Log# 008447-18 CIS# 2129-000010-18 related to responsive behaviors.
Log# 022378-18 CIS# 2129-000025-18 related to alleged staff to resident neglect.
Log# 006513-18 CIS# 2129-000009-18 related to alleged staff to resident abuse.
Log# 019556-18 CIS# 2129-000023-18 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, the Residents' Council representative, the Family Council representative, Executive Director, the Regional Manager of Clinical Services, the Regional Education Manager, the Recreation Manager, the Assistant Director of Care, the Environmental Services Manager, two Registered Nurses, one Resident Assessment Instrument Coordinator, three Registered Practical Nurses, 13 Personal Support Workers, one Food Service Worker, and two Environmental Service Workers.

During the course of the inspection, the inspectors toured all resident home areas, observed dining services, medication administration and, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices, observed maintenance and housekeeping practices, reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **2 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of the homes medication incidents for a specific time fram, was completed.

A medication incident dated for a specific date, stated that RPN #108 administered a specific medication, at a specific time to resident #006.

Review of resident #006's clinical record showed that resident #006 did not have a specific medication, ordered.

September 20, 2018, Executive Director #100 stated that resident #006 was administered a specific medication, at a specific time, on a specific date, and should not have had this medication administered.

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During stage one resident interviews, resident #010 shared with the inspector that they thought the chairs in the home were dirty.

Observation of each unit's chairs in the common areas and dining rooms, showed that there were several pink arm chairs that were stained or soiled.

In an interview with PSW #123, they said that they thought the pink chairs were gross, and would often remove soiled chairs from the common areas to the soiled utility room for cleaning by the housekeeper.

In an interview with PSW #126, they said that the pink chairs were disgusting because they looked stained or soiled. They also said that when they saw a soiled chair they remove it to the soiled utility room for the housekeeper to clean.

Review of the Family Council meeting minutes for a specific date, showed a comment that "An idea of resident's families covering chairs with baby mattress covers to prevent soiling was mentioned by a Council member."

In an interview with the Environmental Supervisor #125, they shared that there was a schedule in place for the deep cleaning of chairs, and the chairs were reviewed by the housekeeper to determine the chairs that needed shampooing and the chairs that just needed spot cleaning. Each unit should have their chairs reviewed once a month for appropriate cleaning by housekeeping. There was no specific documentation related to

which chairs were deep cleaned, the documentation only showed that the chairs were cleaned on a specific date on a specific unit.

Review of the 2018 calendar provided by the Environmental Supervisor that documented when chairs were cleaned on each unit, showed that in February the chairs on Douglas Sadler unit and the James Brian units were not cleaned, in March the chairs on the John Milne unit and the Margaret Brown unit were not cleaned, in April the chairs on the John Milne unit and the Margaret Brown unit were not cleaned and in May the chairs on the John Milne unit and the Margaret Brown unit were not cleaned.

The Environmental Supervisor and the inspector observed the dining room chairs on the John Milne House unit on September 27, 2018, and observed several stained pink chairs in the dining room. They said that the deep cleaning was completed as required, but the chairs were so old and stained, that when they were deep cleaned and let dry, the stains return within a couple days. They shared that those pink chairs have been in the home since they opened in 2002, and they had only received enough funding to replace half the chairs in the home, and those were blue arm chairs that looked clean upon observation of the units.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

Issued on this 1st day of October, 2018

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

Original report signed by the inspector.