Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2019	2019_790730_0038	023595-19	Critical Incident System

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

CHRISTINA LEGOUFFE (730)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 18 and 20, 2019

The following Critical Incident Systems (CIS) inspection was completed:

CIS #2129-000041-19/ Log #023595-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, a Registered Nurse (RN), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. (10) 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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

The Ministry of Long-Term Care (MOLTC) received Critical Incident Systems (CIS) report on a specified date. This CIS report was related to a fall for resident #001, which resulted in a transfer to hospital and a significant change in the resident's health status.

A review of the assessments section in Point Click Care (PCC), for resident #001, included a Safe Lift and Transfer (SALT) assessment. This assessment indicated that resident #001 was assessed to need specified assistance for transfers on day, evening, and night shifts.

A review of resident #001's plan of care in PCC, included a focus related to transferring. Interventions for this focus included a different level of assistance from what was specified by the SALT assessment.

During an observation of resident #001's room, inspector #730 observed a logo above the head of resident #001's bed, which indicated that they required the style of transfer that was indicated by the plan of care.

During an interview, Personal Support Worker (PSW) #102 said that they looked at the logo at the head of a resident's bed to know what their transfer status was. PSW #102 said that resident #001 required a specified level of assistance for transfers, but their plan of care was not updated to reflect this change.

During an interview, Registered Practical Nurse (RPN) #103, said that they looked at a resident's plan of care or the logo in their room to know what their transfer status was. They said that transfer status was assessed by registered staff using the SALT assessment in PCC. The RPN said that resident #001 currently required a specified transfer style, after their most recent SALT assessment, but that their care plan had not been updated. They said that they expected that the plan of care would have been updated after the assessment to reflect the change.

The licensee has failed to ensure that resident #001's plan of care was revised when their transfer status changed. [s. 6. (10) (b)]

Issued on this 2nd day of January, 2020

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

Original report signed by the inspector.