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
May 28, 2020	2020_678590_0006	003342-20	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

ALICIA MARLATT (590)

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): March 3 - 6 and 9, 2020.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, two Registered Practical Nurses, one resident and one family member.

During the course of the inspection, the inspector(s) observed the posting of required information and infection prevention and control practices.

During the course of the inspection, the inspector(s) reviewed three residents clinical records, email and letter correspondence between the home and family members, the homes internal investigation notes, memos to registered staff members, one Infoline report and written policies and procedures related to the inspection topics.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was received by the Ministry of Long-Term Care (MOLTC) expressing concerns about not being informed about a new medication being started for resident #001. On the Infoline report the complainant shared that a medication had been started on a specific day, when the physician had assessed the resident and that they had not been provided the opportunity to consent for it, prior to it being administered to the resident.

In a pre-inspection interview with the complainant, they shared that the medication was actually started seven days prior to the previously mentioned date. They shared that resident #001 was not cognitively well enough to provide consent for medications or health procedures and that up to this point, they had been made aware of any and all medication changes by the nursing staff.

Review of resident #001’s physician’s orders showed an order written on a specific day, to start Ran identified medication. The area to document notifications of the order, was empty. The inspector also reviewed the progress notes after the day the medication was ordered, and observed no notes documenting anything about consent for the identified medication.

Review of the home’s procedure described as LTC - Informed Consent to Treatment, Index: CARE15-O10.03, and last reviewed on March 31, 2019, was completed. It provided a definition of informed consent being ‘the agreement of an individual to a medical treatment based on full disclosure of the treatment to the individual, including treatment plan or procedure, purpose, anticipated outcomes, benefits, and risks.' Further, it described components of an informed consent and that informed consent must be obtained from the Resident/SDM with every treatment and documented.

In an interview with Registered Practical Nurse (RPN) #111 they shared that they were working the day shift on the specific day the medication was ordered. They shared that they worked the full-time day shift opposite to another full-time afternoon RPN, and that their routine together up to this point had been efficient. They confirmed that to process a medication order it was required to be checked and signed by two nurses. They recalled that on that specific day they did not have time to fully process the medication order. They said that included notifying the complainant of the medication order, but also had

not checked the notification box as completed, so knew that RPN # 114 would follow up the order and complete it on their shift as usual. The RPN shared that resident #001 was not cognitively able to consent to medications and that the complainant had been really involved in the resident's care and was always notified of medications prior to this, by themselves or their partner RPN on afternoons.

In an interview with RPN #114 they shared that they had worked the afternoon shift on that specific day. They shared that they worked the full-time afternoon shift opposite RPN #111 and had a great routine for completing orders between them and that they took full responsibility for the missed notification. They shared that it had never happened before, and would be sure moving forward that all the appropriate people were notified as needed in a timely manner.

In an interview with Director of Care (DOC) #101 they shared that this was an unfortunate miscommunication on the homes part. The DOC shared that the complainant had always provided consent for medications and had been involved in their care and would expect the staff to have notified them of the start of the medication. The DOC shared that RPN #114 took full responsibility when asked about the situation, however this incident raised questions for them about the medication order process in the home regarding what constituted a first and second check of orders. The DOC shared that they would be asking all registered staff about their individual processes to identify any education needs amongst the staff regarding the processing of physician's orders. [s. 6. (5)]

Issued on this 1st day of June, 2020

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

Original report signed by the inspector.