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
Jul 21, 2021	2021_790730_0025	005629-21, 006126-21	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

CHRISTINA LEGOUFFE (730), KRISTEN MURRAY (731)

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): July 7, 8, 9, 13, 14, and 15, 2021.

The following complaint inspection was conducted:

Log #006126-21 related to falls prevention
Log #005629-21 related to safe lifts and transfers.

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

The inspectors 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, reviewed policies and procedures of the home, and the home's complaint records.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when they assisted a resident.

The Ministry of Long-Term Care (MLTC) received a complaint related to a resident being left with an assistive device over top of them for an extended period of time. There was evidence to support that the device remained in place over top of the resident for an extended period of time.

The resident told an Inspector that they had concerns about an incident where they were left with an assistive device above them for a long period of time. A Personal Support Worker (PSW) said that the resident often exhibited responsive behaviours. They said that the expectation was that if a resident was exhibiting responsive behaviours while using the assistive device that staff would ensure that the resident was safe and re approach the resident at a later time. They said that a resident should never be left attached to the assistive device, or with the device above them, without staff present and that the device should not be left in a resident room with a resident present. There was no documentation noting that the resident was exhibiting responsive behaviours at the time of the incident.

The Director of Care (DOC) said that a resident should never be left attached to the assistive device and would not be considered safe if they were attached to the device unattended. The DOC said that they would not have expected the assistive device to have been left in place for such a long period of time and that the actions of the staff involved did not meet the home’s expectations for safe lifts and transfers.

As a result of the incident there was a risk of harm to the resident.

Sources: Resident clinical records including their plan of care, photos, and interviews with the DOC and other staff. [s. 36.]

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 home uses safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument.

A resident sustained a fall and a post fall assessment was not completed.

The home's fall prevention policy required a member of the registered nursing staff to complete a post fall assessment after a resident sustains a fall.

The Director of Care (DOC) stated that when a resident sustained a fall the post fall assessment was to be completed for the resident. When asked if a post-fall assessment should have been completed for the resident's fall, the DOC stated yes. There was minimal risk of harm related to the resident not having a post fall assessments completed.

Sources: "Post-Fall Management" Policy, number "CARE5-O10.05" (last revised March 2021; resident progress notes and assessments; and interviews with the DOC and other staff. [s. 49. (2)]

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 when a resident falls, a post-fall assessment is conducted using a clinically appropriate assessment instrument, to be implemented voluntarily.

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Issued on this 23rd day of July, 2021

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

Original report signed by the inspector.