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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 7, 2014	2014_188168_0022	H-001252-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

Long-Term Care Home/Foyer de soins de longue durée

KILEAN LODGE
83 MAIN STREET EAST, GRIMSBY, ON, L3M-1N6

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

LISA VINK (168), GILLIAN TRACEY (130), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 29, 30, October 1, 2, 3, and 7, 2014.

The following inspections were completed concurrently with the RQI, Complaint Inspection, log number H-000879-13 and Critical Incident Inspection, log number H-000889-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care (ED/DOC), Associate Director of Care (ADOC), Office Manager, Activation Manager, Environmental Services Manager, Registered Nursing staff, Personal Support Workers (PSW), front line staff, families and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured to home, reviewed relevant records including but not limited to: policies and procedures, meeting minutes, incident reports and logs, and relevant clinical records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure that the policy instituted or otherwise put in place was complied with.

A review of the "Pain Assessment and Symptom Management Policy, LTC-E-80, last reviewed August 2012," indicated that "staff must initiate a Pain Monitoring Tool when pain has been identified".

On September 30, 2014, resident #103 stated that they had pain due to an incident. A review of the clinical record indicated that on September 22, 2014, the resident reported to staff an incident which resulted in the pain, however staff did not complete a pain assessment until September 24, 2014. Interview with registered staff confirmed that staff did not comply with the Pain Assessment and Symptom Management Policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 polices that the home puts in place are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident with altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. Resident #104 sustained a skin tear in September 2014. A review of the resident's clinical record indicated that staff assessed the skin tear and documented the assessments in the records; however, were not using a clinically appropriate assessment instrument. It was confirmed by the ED on October 3, 2014, that the resident's skin tear was not assessed using a clinically appropriate instrument. (508)
B. Resident #105 was identified to have a skin tear in August 2014, according to the progress notes. A skin assessment using a clinically appropriate assessment instrument was not completed until approximately one week later, as identified in the clinical record and confirmed during staff interview. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident with altered skin integrity was assessed by a Registered Dietitian (RD) who was a member of the staff of the home.

A. Resident #104 sustained a skin tear in September 2014. A review of the clinical record did not include a referral to nor an assessment by the RD for the area of altered skin integrity. Interview with ED confirmed that an assessment was not completed for the skin tear by the RD, as a referral was not completed. (508)

B. Resident #105 was identified to have a skin tear in August 2014. A review of the clinical record did not include a referral to nor an assessment by the RD for the area of altered skin integrity. Interview with registered staff confirmed that an assessment was not completed for the skin tear by the RD, as a referral was not completed. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that the resident with altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Resident #105 was identified to have a pressure ulcer on an extremity. This area was not consistently reassessed at least weekly by a member of the registered nursing staff. The area was not assessed weekly between June 30, 2014 and July 12, 2014, between August 14, 2014 and August 31, 2014, and between September 8, 2014 until October 1, 2014. Record review and interview with registered staff confirmed that the identified assessments were not completed.
B. Resident #105 was identified to have a pressure ulcer on their torso. This area was not reassessed at least weekly by a member of the registered nursing staff between September 5, 2014 and September 16, 2014, as confirmed during record review and staff interview. (168) [s. 50. (2) (b) (iv)]

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 resident with altered skin integrity is assessed by a Registered Dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that the resident's right to participate in decision-making was fully respected and promoted.

Resident #107 had a diagnosis and was ordered a specialized diet with additional restrictions. During an interview on September 29, 2014, the resident reported that staff had recently removed a specific food item from their room without their consent. Staff interviewed on October 2 and October 3, 2014, indicated that the resident kept the specific food in their room and would consume more than prescribed.
A review of the clinical record indicated that the resident was competent and could make decisions regarding their care. Interview with the resident and the registered staff on October 3, 2014, confirmed that the resident was competent and understood the consequences of consuming the additional food.
Staff confirmed on October 3, 2014, that they had removed the food without the resident's consent and that their rights were not fully respected and promoted. [s. 3. (1) 9.]

WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

On September 29, 2014, resident #104 was not wearing lower dentures. Interview with the resident on October 2, 2014, confirmed that they do not wear bottom dentures, only uppers. Staff interviewed confirmed that the resident was admitted to the home without lower dentures and only wears uppers. A review of the plan of care indicated that the resident had both upper and lower dentures, which staff confirmed was not clear direction related to oral care needs. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The Resident Assessment Protocol (RAP) completed by nursing staff in June and August 2014, for resident #106, identified a pressure ulcer on the right extremity. The RAP completed by dietary during the same time period identified a pressure ulcer to the left extremity. The written plan of care, the physician's order and staff confirmed the pressure area was to the left extremity. [s. 6. (4) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's customary routines.

During an interview resident #110 stated they received a shower twice a week, but would prefer to have a bath. The resident was not able confirm whether or not this information had been communicated to the front line staff. The plan of care was reviewed with the registered staff, who confirmed the resident's preference for a bath had not been identified in the written plan of care. [s. 26. (3) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

The Physiotherapist Assessment completed for resident #111 on September 8, 2014, indicated they required a four point seat belt as a restraint. The resident was observed with the device applied and staff interviewed confirmed that they were unable to unfasten the device. On October 7, 2014, registered staff confirmed that there was not a current physician's order for the device in use as required. [s. 30. (1) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in a locked area.

It was identified on October 3, 2014, that discontinued controlled substances were being stored in a locked medication room, on the second floor, in a single locked portable cabinet. Interview with registered staff confirmed that they were using this cabinet to store discontinued controlled substances. Interview with the ED, confirmed that the cupboard used to store discontinued controlled substances was a portable, single locking cabinet. [s. 129. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

The licensee failed to ensure that, a written record was created and maintained for each resident of the home.

Resident #106 was identified with a pressure ulcer. Registered staff confirmed that weekly skin assessments were completed and filed in the wound care binder located on the second floor unit. On October 7, 2014, the ED and registered staff completed a search of the area but were unable to locate the binder. The resident's written record was not maintained. [s. 231. (a)]

Issued on this 4th day of November, 2014

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