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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 29, 2015	2015_214146_0013	H-002761-15	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

BARBARA NAYKALYK-HUNT (146), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), PHYLLIS HILTZ-BONTJE (129)

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): July 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 2015

Complaint inspections #019245-15, #014613-15 and Critical Incident inspections #009267-14, #004954-15 and #018134-15 were conducted concurrently with the RQI and findings of non-compliance are included in this report.
During the course of the inspection, the inspectors toured the home; reviewed residents' health records, internal investigation notes, meeting minutes, policies and procedures; and observed residents in care areas.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED)/ Director of Care (DOC); Associate Director of Care (ADOC); Food Service Manager (FSM); Environmental Manager; Recreation Manager; Office Manager; registered staff; dietary staff; housekeeping staff; Personal Support Workers (PSW's); hairdresser; social worker; residents and family members.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
10 WN(s)
3 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 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

An incident occurred between a resident and an identified staff member on a date in December 2014. The incident was identified by the ED as being inappropriate in nature and the resident expressed being fearful of the staff member. The actions of the staff member did not fully recognize the resident's individuality and did not respect the resident's dignity. The ED confirmed the incident and the outcome of the investigation. (611) [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 2. Every resident has the right to be protected from abuse.

A) The Home's policy #LP-C-20-ON entitled "Resident Non-Abuse – Ontario" with a revision date of September 2014, defined verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident". Examples provided in the document include, but are not limited to, abusive language and swearing.
PSW #1 reported witnessing, in February 2015, PSW #2 verbally abusing a resident. This information was confirmed by the homes internal investigation notes. The resident's right to be protected from verbal abuse was not respected or promoted. (510)

B) Resident #001 reported that, in July 2015, an identified staff person had verbally abused the resident. The resident was threatened by the staff person's statement and anxious and fearful.
The verbal abuse was overheard and described as yelling and abusive by an identified complainant.

The communication from the staff person had threatened and intimidated resident #001 which diminished the resident's sense of well being as evidenced by the fear and anxiety expressed during the interview with the inspector. Resident #001 had been verbally abused by the identified staff person. This information was confirmed by the resident and the complainant in separate interviews but denied by the staff person. (146) [s. 3. (1) 2.]

3. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 11. Every resident has the right to, iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

In July 2015, two visitors were observed behind the desk at the nursing station. Two resident health records were open on the desk, with personal health information (PHI) evident. The chart rack was also in this area making all charts accessible to these visitors. Registered staff confirmed PHI was open and accessible to anyone behind the desk. Resident PHI, within the meaning of the Personal Health Information Protection Act, 2004, was not kept confidential. [s. 3. (1) 11. 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 following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and 2. Every resident has the right to be protected from abuse, 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 has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #008 had a wound which was not consistently reassessed weekly; specifically an assessment was not completed for 12 days on one occasion; for 13 days on a second occasion; for 12 days on another occasion; and 16 days on another occasion. Registered staff and the ADOC confirmed that these assessments were not completed.

B) Resident #032 developed a wound as identified on an initial wound assessment-treatment observation record in April 2015. This area was not consistently reassessed weekly; specifically, a weekly wound assessment was not completed on two occasions for a period of 12 days and 14 days respectively. Registered staff confirmed that these assessments were not completed. [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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

The home's Policy #LP-C-20-ON, entitled "Resident Non-Abuse- Ontario" directed that all staff who provide direct care would receive training annually on the Resident Non-Abuse Program.
The document entitled 'Worksheet for Tracking Completion of Mandatory Training' reported that 86% of the home's staff had completed the Resident Non-Abuse Program in 2014/2015.
The home's hairdresser confirmed that, after being employed for five years, no training on prevention of abuse had been provided to the hairdresser yet.
All staff who provided direct care to residents did not receive 2014/15 annual training related to abuse recognition and prevention. This was confirmed by the home's documentation. [s. 221. (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 all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1)(a), and every action taken under clause (1)(b).

In March 2015, Critical Incident Report #1866-000002-15 was submitted to the Ministry of Health and Long Term Care (MOHLTC), reporting an allegation of abuse. In an interview in July 2015 the ED stated that the home was unable to conclude the investigation. The ED confirmed that the home had not provided the information regarding the outcome of the internal investigation in a CI amendment. [s. 23. (2)]

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:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on the resident's hydration status and the risks related to hydration.

A) The health record, specifically the MDS assessment from March 2015, indicated that resident #013 was at risk for dehydration. The plan of care did not address the dehydration risk. The Resident Assessment Instrument (RAI) coordinator confirmed that the plan of care should have been based on the dehydration risk but did not address the risks related to hydration. [s. 26. (3) 14.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device was included in the resident's plan of care only if 5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #031 had a restraining device applied. Interview with registered staff revealed that the home obtains written consent for restraints annually, at the time of the care conference. Policy #LTC-K-10, entitled "Least Restraints" directed that the resident/SDM's consent for initial restraint application or change in type of restraint will be obtained, and consent reviewed annually. Registered staff confirmed the absence of a signed consent for resident #031 in the past 18 months. [s. 31. (2) 5.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied: 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #028 was observed using a device which, according to the health record, was a PASD. Registered staff confirmed that the home's policy and expectation is that consents for PASD's be re-done annually. Registered staff confirmed that the consent for resident #028's PASD had not been renewed since February 2013. [s. 33. (4) 4.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council was sought, in developing and carrying out the satisfaction survey, and in acting on its results.

Review of Resident Council minutes revealed the documentation of suggested improvements and or changes for the survey process. There was no evidence in the minutes that Resident Council input was sought in the development of the satisfaction survey questions. The Recreation Manager and Resident Council Chair confirmed that Resident Council did not provide input in the development of the satisfaction survey. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report made in writing to the Director about an incident described in r. 107 (1), (3) or (3.1) included the following:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

A) A Critical Incident Report was submitted for resident #017 in December 2013. The identified incident resulted in an injury and transfer to hospital. A request was made by The Ministry of Health and Long Term care through the Critical Incident Reporting system for more information. The ED confirmed that the request for amended/added information was not submitted.

B) A Critical Incident (CI) Report was submitted for resident #033 in November 2013. On two later dates in November 2013, the Ministry of Health and Long Term Care requested an amendment and further information related to the CI. This information was not sent as confirmed by the ED. [s. 107. (4) 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the program.

Review of the care plan for resident #037 revealed a focus for contact precautions related to an identified diagnosis. A laboratory report confirmed the diagnosis. Registered staff confirmed the absence of signage noting required precautions on the door to the room of resident #037 and also confirmed it is the homes expectation that appropriate signage be posted. The infection prevention and control program was not implemented as confirmed by registered staff. [s. 229. (4)]

Issued on this 9th day of October, 2015

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

Original report signed by the inspector.