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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 2, 2017	2016_561583_0025	006411-16	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

KELLY HAYES (583), 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): November 28, 29, 30, 2016, and December 1, 6, 7, 8, 9, and 12, 2016.

The following inspections were conducted simultaneously with this Resident Quality Inspection: Complaint Inspection log #029373-15, related to responsive behaviours and falls; Complaint Inspection log #033952-15, related to alleged staff to resident abuse; Complaint Inspection log #035294-15, related to responsive behaviours and resident discharges and Critical Incident System Inspection log #031886-16, related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED); Programs Manager; Registered Nursing (RN); Registered Practical Nurse (RPN); Personal Support Workers (PSW); family members and residents. During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, and clinical health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **6 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan.

Resident #301 had responsive behaviours. The home implemented one implemented an intervention to increase the monitoring of resident #301 and to minimize the risk of resident to resident altercations.

On and identified date in 2015, resident #301 wandered into resident #300's room and an altercation occurred between the two residents. Resident #300 sustained an injury.

Review of documentation indicated the intervention had been implemented by the home at the time of the incident; however, was not being implemented by the direct care staff.

It was confirmed during an interview with the Executive Director (ED) on December 9, 2016, that the care set out in the resident's plan of care had not been provided to the resident as specified in the plan.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #029373-15, conducted concurrently during this RQI. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to Critical Incident System log #031886-16 , resident #302 who had known responsive behaviours, grabbed and held a firm grip on staff #002's arm during care. Staff #001 who was also provided care to resident #302 at this time intervened by applying physical force on the resident in an attempt to release resident #302's grip.

The resident sustained an injury related to this incident. It was confirmed through an interview with the ED and through review of the home's internal documentation that resident #302 was not protected from abuse by anyone and free from neglect by the licensee or staff in the home.

PLEASE NOTE: This non-compliance was identified during a critical incident system inspection, log #031886-16, conducted concurrently during this Resident Quality Inspection. [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents, annual retraining in the area of skin and wound care in accordance with O. Reg. 79/10, s. 221(1) 2.

In an interview with the ED it was confirmed that 54 staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that zero out of 54 staff had received training in the area of skin and wound care in accordance with O. Reg. 79/10, s.221(1)2. This was confirmed in an interview with the ED on December 12, 2016. [s. 76. (7) 6.]

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 staff of the home have received training as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that all equipment, supplies, devices, assistive aids and positioning aids in the home were used in accordance with manufacturers' instructions.

A tub chair was observed during a tour of the home on November 28, 2016, on the second floor in the tub/shower room and no lap belt was present. The tub chair was not currently being used to assist residents with positioning during their baths; however, staff confirmed the tub chair was being used to weigh residents as the chair had a digital scale without the application of a lap belt.

According to manufacturers' instructions for the chair lift, residents were to be secured when in the chair with a lap belt.

In an interview with the Executive Director and with staff #100 on November 28, 2016, it was identified that no lap belts were available in the home for staff to use. It was confirmed that all equipment, supplies, devices, assistive aids and positioning aids in the home were used in used in accordance with manufacturers' instructions. [s. 23.]

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 staff use all equipment and devices in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

In an interview with staff #150 on December 9, 2016, it was confirmed that resident #201 alleged they received rough care which caused pain from a PSW on an identified date in 2015. It was confirmed that the incident was immediately reported to the RN on duty and the ED. Staff #150 shared they were present when a written statement was taken from resident #201 as part of the alleged abuse investigation.

A review of the Investigation of Abuse or Neglect, ADMIN1-010.02 policy, effective August 31, 2016, stated "The ED/designate will maintain confidential files that will include any statements, interview/meeting minutes, and other documentation related to, or generated by, the investigation." A review of the Mandatory Reporting of Resident Abuse or Neglect, ADMIN-010.01 policy, effective August 31, 2016, stated "Mandatory reporting under the LTCHA (Ontario): Section 24(1) requires a person to make an immediate report to the Director of the Ministry of Health and Long Term Care if there is a reasonable suspicion that abuse or neglect occurred or may occur as well as the details to support the suspicion".

In an interview with the ED on December 9, 2016, it was shared the home did not maintain any investigation notes related to the incident and it was confirmed the alleged incident was not documented in resident #201's plan of care. In addition, it was confirmed the home did not make a report to the Director of the Ministry of Health and Long Term Care when there was reasonable suspicion that abuse may have occurred.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #033952-15, conducted concurrently during this Resident Quality Inspection. [s. 20. (1)]

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 policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: 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 residents who exhibited altered skin integrity including pressure ulcers were assessed by a registered dietitian who was a member of the staff of the home.

A review of resident #008's MDS coding under section M. skin condition documented on an identified date in May, 2016, identified that resident #008 had altered skin integrity on an identified area. Progress notes documented on an identified date in April, 2016, identified a Personal Support Worker (PSW) initially notified registered nursing staff of resident #008's altered skin integrity. An electronic referral was sent to the Registered

Dietitian (RD) on an identified date in June 2016. In an interview with staff #122 it was confirmed a referral was not made to the RD when resident #008 first developed an alteration of their skin. It was confirmed a referral was made approximately two months later at which time the residents altered skin had worsened. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that residents who exhibited altered skin integrity including pressure ulcers were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

A review of resident #008's MDS coding under section M. skin condition documented on an identified date in May 2016, identified resident #008 resident had altered skin integrity. On an identified date in April 2016, it was documented that a PSW initially notified the registered nursing staff of resident #008's altered skin integrity. The home's clinically appropriate assessment instrument was first initiated for the altered skin on an identified date in June 2016, at which time the condition of skin had worsened.

A documented assessment was not found in the resident's paper or electronic record that identified the altered skin had healed. In an interview with staff #101 on December 12, 2016, they confirmed that the area of altered skin was healed but they could not confirm what date it had resolved.

A review of resident #008's MDS coding under section M. skin condition documented on an identified date in August 2016, identified the resident had alteration to their skin. On an identified date in June 2016, it was documented that a PSW initially notified registered nursing staff of resident #008's altered skin integrity on an identified area. On an identified date in June 2016, the physician prescribed a treatment and a referral was made to the RD to assess for altered skin integrity. The home's clinically appropriate assessment instrument was initiated for the altered skin on an identified date in October 2016, at which time it was assessed to have worsened. A documented assessment was not found in the resident's paper or electronic record that identified the altered skin had healed. A progress note documented on an identified date in November 2016, identified resident #008 had altered skin integrity on the same area. In an interview with staff #101 on an identified date in December 2016, it was confirmed resident had an area of altered skin integrity.

In an interview with staff #122 on December 12, 2016, it was confirmed that:

i) Resident #008's altered skin was not reassessed weekly between identified dates in April and June 2016.
ii) Resident #008's altered skin was not reassessed weekly between identified dates in June and October 2016 or between identified dates in November and December, 2016.

It was confirmed resident #008's weekly assessments were not complete until the wound champion was referred. [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 who exhibit altered skin integrity including pressure ulcers are assessed by a registered dietitian who is a member of the home and are reassessed at least weekly by a member of the registered nursing staff when clinically indicated, to be implemented voluntarily.

Issued on this 8th day of February, 2017

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

Original report signed by the inspector.