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 soins de longue durée

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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
Jun 7, 2017	2017_323130_0013	008935-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

GILLIAN TRACEY (130), CATHIE ROBITAILLE (536), KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)

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): May 8, 9, 10, 11, 12, 2017.

The following onsite inquiries were conducted during this RQI: #008720-17 and 008626-17.

During this inspection, the home was toured, care was observed, medication administration was observed, staff, residents and families were interviewed, clinical records, investigation notes and relevant policies and procedures were reviewed.

Please note: During this inspection, Monica Giammarco, Administrative Assistant with the Hamilton Service Area Office was present for the purpose of observing the inspection process.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care (ED/DOC), Assistant Director of Care (ADOC), registered staff, personal support workers (PSWs), housekeeping staff, Regional Director, President of the Residents' Council, President of the Family Council, residents and families.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

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

4 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 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licencee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment with respect to the residents' sleep patterns and preferences.

A) The plan of care for resident #005, revealed the resident was cognitively impaired and had a diagnosis that limited their independence with activities of daily living and put them at risk for impaired skin integrity. The plan revealed the resident had interventions in place to manage this risk of impaired skin.

The resident was observed at different times on a specific shift in 2017. The resident was asleep in their wheelchair at each observed time. Staff interviewed on the day shift acknowledged the resident was not put back to bed during the day shift.

The plan of care was not based on an assessment of the resident's sleep patterns, preferences nor did it provide direction to staff regarding the resident's rest routines during the day.

This information was confirmed by the ED/DOC. (Inspector #130).

B) The plan of care for resident #003 revealed the resident was totally dependent on staff for all aspects of care due to a specific diagnosis; had impaired skin and alteration in comfort; was at risk for impaired skin integrity due to their diagnosis; had interventions in place and required specific care interventions related to their diagnosis.

The resident was observed at specific times in 2017. The resident was asleep in their wheelchair at each observed time. Staff interviewed acknowledged the resident was not put back to bed during the day shift.

The plan of care revealed the resident often fell asleep in their chair; however, the plan of care was not based on an assessment of the resident's sleep patterns, preferences or rest routines.

This information was confirmed by the ED/DOC. (Inspector #130). [s. 26. (3) 21.]

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 plan of care is based on, at a minimum, interdisciplinary assessment with respect to the residents' sleep patterns and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

A) The plan of care for resident #005, revealed the resident had a specific diagnosis, had alterations in comfort, was at risk for impaired skin integrity related to their diagnosis and was totally dependent on staff for continence care. The goal identified in the plan of care was to avoid specific conditions to help minimize the risk of skin impairment.

On a specified date in 2017, the resident was observed for a period in excess of two hours over a specific time period. Staff #134 was assigned to provide care to the resident during their shift. They confirmed in an interview, that they had not provided continence care to the resident over a period in excess of seven hours.

The ED/DOC acknowledged that by the identified staff had not provided continence care to the resident over the identified number of hours, the specific condition that put the resident that risk, had not been avoided.

Please note: This non compliance was issued as a result of the RQI, but related to CI #018134-15. (Inspector #130).

B) The plan of care for resident #003 revealed the resident was totally dependent on staff for all aspects of care due to a diagnosis, had alterations in comfort and impaired skin integrity.

On an identified date in 2017, the resident was observed asleep in their wheelchair at a specified time. Staff #134, who was assigned to provide care to the resident during their shift said in an interview that they had provided continence care to the resident early in the day with an identified coworker. The coworker was interviewed and denied assisting staff #134 with any continence care to the resident that day.

The Administrator acknowledged that resident #003 did not receive continence care as required. (Inspector #130). [s. 51. (2) (g)]

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 require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #3: 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 :

1. The licensee failed to comply with manufacturer's instructions for the storage of drugs.

A) On an identified date in 2017, the drug storage room was observed and noted to contain Bisacodyl 5 milligram (mg) tablets that had an expiration date of May 2017, Bisacoydyl Suppositories that had an expiration date of April 2017 and Ferrous Gluconate 300 mg tablets that had an expiration date of March 2017.

The ADOC acknowledged the medications observed in the drug storage room had expired and should have been removed from the general stock on the first day of the month that the manufacturer had specified they would expire.

The manufacturer's instructions for the storage of drugs was not complied. (Inspector #130). [s. 129. (1) (a)]

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 the licensee complies with manufacturer's instructions for the storage of drugs, to be implemented voluntarily.

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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 plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) A review of the plan of care, which the home referred to as the care plan revealed that resident #006 was independent with an activity of daily living (ADL). On an identified date in 2016, resident #006 sustained a fall with injury, which resulted in a significant change in condition. A review of the Minimum Data Set Assessment (MDS) dated in 2016, revealed the resident required extensive assistance with one staff member for the ADL. A review of Task records completed by staff over six days during the same time period, revealed the resident required extensive assistance for three days during the observation period. Staff #108 and #121 acknowledged the resident required supervision for the ADL and not extensive assistance as revealed in the MDS assessment. The ADOC/Staff Educator acknowledged that care set out in the plan of care for resident #006 was not based on the assessment of the resident related to the ADL. (Inspector #632). [s. 6. (2)]

2. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM had been given an opportunity to participate fully in the development and implementation of the plan of care.

A) The plan of care for resident #003 revealed the resident was totally dependent on staff for all aspects of care due to their diagnosis, had impaired skin, an alteration in comfort

and had interventions in place to manage comfort and risks related to skin integrity. The plan also revealed that interventions were in place to manage specific risks, their diagnosis and that the SDM would be integrated into their care.

A progress note recorded in 2016, revealed that the SDM had requested that a specific intervention be put in place for the resident's comfort. The same note indicated that the SDM's request would be communicated to front line staff.

The resident was observed at various times during the day shift on a specific date in 2017.

The current care plan was reviewed and had not identified the SDM's requested intervention. Staff #134 acknowledged the intervention had not been implemented on the observed date.

The SDM for resident #003 had not been given an opportunity to participate fully in the development and implementation of the plan of care. (Inspector #130). [s. 6. (5)]

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

A) The plan of care for resident #011, revealed they required extensive assistance of one staff with a specific ADL.

On an identified date in 2017, the resident reported that on a specific shift they summoned staff to help with the ADL. PSW #139, responded to the summon, but did not assist with the ADL, as they had requested.

The home’s internal investigation concluded that PSW #139, did not provide the resident with the required assistance on the identified date.

The ED/DOC acknowledged that PSW #139 did not provide resident #011, with the level of assistance they requested and as specified in the plan of care.

On the identified date in 2017, care was not provided to resident #011 as specified in the plan of care.

Please note: This non compliance was issued as a result of CI #001573-17, which was

conducted concurrently with the RQI. (Inspector #130). [s. 6. (7)]

Issued on this 27th day of June, 2017

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

Original report signed by the inspector.