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
Mar 8, 2022	2022_905683_0002	003142-22	Proactive Compliance Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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 BOS (683), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): February 23-25, 28 and March 1-2, 2022.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC)/Infection Control and Staff Educator, Nutrition/Environmental Services Manager, Recreation Manager/Volunteer Coordinator, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary staff, housekeeping staff, recreation staff, screening staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, infection prevention and control (IPAC) practices, meal service, medication administration, and reviewed clinical records, relevant policies and procedures, meeting minutes, training records, temperature reports and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

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

7 WN(s)
1 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. 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 participated in the implementation of the Infection Prevention and Control (IPAC) program related to resident hand hygiene and signage for residents on additional precautions.

A) During nourishment pass, a Personal Support Worker (PSW) was observed to serve three residents a beverage without immediate prior assistance with hand hygiene. The staff confirmed that they had not provided hand hygiene prior to the distribution of the nourishment.

The home's procedure related to Safe Eating Assistance, identified that all residents should be provided assistance with hand hygiene prior to mealtimes. The Executive Director (ED) confirmed that this included snack times and was an expectation of the hand hygiene program.

Failure to comply with the home's Hand Hygiene Program presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that might have been on their hands.

Sources: Observations of nourishment pass; review of the Safe Eating Assistance and Hand Hygiene programs; interview with a PSW and other staff.

B) The home's Droplet Precautions policy identified that signage was to be visible on entry to the room for residents who required additional precautions.

According to the Associate Director of Care (ADOC), a resident was placed in the home's isolation room with contact/droplet precautions in place.

The resident was observed in the isolation room and there was no signage posted

outside the door to indicate that the resident was on contact/droplet precautions.

A RPN and PSW acknowledged that the resident was still on droplet/contact precautions and that there should have been a sign to indicate that additional precautions were required.

Lack of appropriate signage outside the isolation room may have prevented staff and visitors from wearing the required personal protective equipment (PPE).

Sources: Droplet Precautions policy; observations; interview with a PSW, RPN and the ADOC. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: 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. (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 has failed to ensure that a resident's assistive device was in place, as per their plan of care.

A resident required an assistive device during meals.

The resident was observed during the lunch meal, and they did not have the assistive device in place, as per their plan of care.

The Registered Dietitian (RD) acknowledged that the resident required the assistive device during meals and that it should have been in place.

Sources: A resident's clinical record; resident observations; interview with the RD and other staff. [s. 6. (7)]

WN #3: 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 :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute, or otherwise put in place any policy or procedure, that the policy or procedure was complied with.

LTCHA s. 11 (1) (a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

O.Reg. 79/10, s. 73 (1) 6 requires that food and fluids are served at a temperature that is both safe and palatable to the residents.

Specifically, staff did not comply with the home's Food Temperature Checklist, which was part of their nutrition care and dietary services program. The procedure indicated that temperatures were to be taken at the end of the cooking process and recorded on the Cook's Meal Production Daily Temperature Record in the Meal Delivery Software. The temperature was to be recorded again at the point of meal service for all diet types and textures on the Meal Service Daily Temperature Record in the Meal Delivery Software.

The temperature record was reviewed for the breakfast and lunch meals for the first and second floors of the home. The temperatures were documented once between 0829 to 0831 hours for each of the breakfast food items which included oatmeal, hard boiled eggs and toast available in all diet textures.

The Nutrition Manager acknowledged that temperatures were supposed to be taken in the kitchen, and again on both the first and second floors, prior to meal service, and documented in the Meal Delivery Software. They reported that there was a system error that morning and the dietary staff took the temperatures as required for the breakfast meal, but they were not saved in the Meal Delivery Software.

The documentation did not reflect that food temperatures were taken in the kitchen, and prior to meal service on the first and second floors, as per the home's Food Temperature Checklist.

Sources: Dining observations; review of the home's Food Temperature Checklist; interview with the Nutrition Manager and other staff. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system could be accessed by residents, staff and visitors at all times.

During a tour of the home, the inspector was not able to activate a resident's communication and response system at the bedside as the push button was not working.

The Environmental Services Manager (ESM) was also unable to activate the call bell and confirmed it would be replaced immediately.

Failure to ensure that the resident-staff communication and response system was accessible at all times had the potential to prevent the resident or staff from alerting others that they were in need of assistance.

Sources: Observations; testing of the communication and response system; interview with the ESM. [s. 17. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under the nursing services program, as required in LTCHA s. 8 (1) were documented.

A review of the clinical record for a resident identified that they had one documented bath over a period of two months.

Interview and review of the bathing records with the RAI Co-ordinator confirmed that the resident received two baths per week as per their preference; however, not all were documented in the resident's clinical record. The RAI Co-ordinator later confirmed there was an error in the way the task was set up for the resident in Point Click Care and that was why baths were not documented.

The resident confirmed they received their baths as scheduled.

The licensee failed to ensure that all baths were documented including the method the resident was bathed, the care required and their responses to the interventions.

Sources: A resident’s clinical record including bathing records; interview with a resident and the RAI Co-ordinator. [s. 30. (2)]

2. The licensee has failed to ensure that any actions taken with respect to a resident under the falls prevention and management program as required in O. Reg. 79/10, s. 48 (1) 1, was documented.

A resident sustained a fall and a referral was sent to the Physiotherapist (PT). A review of the resident’s clinical record did not identify a response to the referral by the PT.

The PT indicated that they received the referral and went to assess the resident, but the resident did not wish to be assessed at that time. They acknowledged that there was no documentation in the resident’s clinical record to indicate that they had gone to assess the resident and that the resident declined to be assessed.

Sources: A resident’s clinical record; interview with the PT and other staff. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used proper techniques to assist a resident with eating.

A resident was at a high nutritional risk. Their written plan of care indicated that they required physical assistance with meals.

The resident was observed during meal service. Throughout the meal, a PSW fed the resident while in a standing position.

The home's Safe Eating Assistance training directed individuals to sit at eye level on the side to which the resident paid the best attention when providing assistance during meals.

The resident reported they did not like when staff stood to feed them, because it felt like they were going to run away.

The PSW acknowledged that they should have sat down while they assisted the resident to eat, but there were no additional chairs available in the dining room at that time.

Sources: A resident’s clinical record; resident observations, review of the home's "Safe Eating Assistance" training document; interview with a PSW and other staff. [s. 73. (1) 10.]

2. The licensee has failed to ensure that a resident was not served a meal until someone

was available to provide the assistance they required.

A resident was at a high nutritional risk. Their written plan of care indicated that they required physical assistance with meals.

The resident was observed during meal service. They were provided their meal and a PSW provided them a few bites to eat and left to serve meals to co-residents. Over the course of the meal, the resident requested assistance from the PSW three times and each time, the PSW provided them a few bites to eat before returning to serve meals to co-residents. The PSW did not stay to provide the resident assistance to finish their meal until twenty minutes after they were initially served.

The resident reported that it made them feel "terrible" when they had to keep requesting assistance to eat.

The PSW acknowledged the resident required assistance with meals. They reported that they were trying to serve co-residents their meals and assist the resident because there were not enough staff to serve the meal.

The Director of Care (DOC) acknowledged that the PSW should have waited to serve the resident their meal until someone was available to provide the assistance they required.

Sources: A resident's clinical record; resident observations; interviews with a resident, PSW and the DOC. [s. 73. (2) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)

(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement entered into in accordance with section 20 of the Local Health System Integration Act, 2006 or section 22 of the Connecting Care Act, 2019;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that an explanation of whistle-blowing protections related to retaliation was posted.

During a tour of the home, posting of an explanation of whistle-blowing protections related to retaliation was not visible in a conspicuous and easily accessible location.

The ED confirmed that this information was not posted.

Sources: Tour of the home; interview with ED. [s. 79. (3) (p)]

Issued on this 9th day of March, 2022

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

Original report signed by the inspector.