Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: September 14, 2023	
Inspection Number: 2023-1043-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Kilean Lodge, Grimsby	
Lead Inspector Olive Nenzeko (C205)	**Inspector Digital Signature**
Additional Inspector(s) Lesley Edwards (506)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 17-18, 21-25, 2023.
The inspection occurred offsite and onsite on the following date(s): August 24, 2023.

The following intake(s) were inspected:

- Intake #00094150 related to Proactive Compliance Inspection (PCI).

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement

Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 20 (a)

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.

Rationale and Summary
The inspector was not able to activate a resident's bathroom communication and response system as the cord broke off when it was pulled.

The communication and response system was fixed the same day.

Sources: Observations; testing of the communication and response system; interview with the ESM. [506]

Date Remedy Implemented: August 17, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 6.1 that the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk.
Long Term Care Home (LTCH) Inspector #506 observed during the initial tour of the home a resident room with contact/droplet precautions posted and there was no PPE caddy beside the resident's door or hanging on the door.
Staff acknowledged that the resident was on contact precautions and the wrong signage was posted and that they required PPE.
Later that day a PPE caddy was placed on the door with the correct signage.

Sources: Observation during the initial tour; interview with staff. [506]

Date Remedied Implemented: August 18, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 148 (2) 2.

The licensee has failed to ensure that controlled substances that are to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substances that are available for administration to a resident.

Rationale and Summary
The Director of Care (DOC) acknowledged that controlled substances that have been discontinued after hours or on a weekend will remain in the narcotic box with controlled substances that are available for administration to residents until the DOC or Acting Director of Care (ADOC) returns to work. The home's policy for "Narcotics and Controlled Drugs" also stated that narcotics and controlled drugs will remain locked in the narcotic bin and be included in the narcotic count until they are picked up by the pharmacy provider for destruction.

The licensee immediately relocated the controlled substance storage area to where registered

staff had access at all times and the policy was updated to reflect this change.

Sources: Observation of the storage unit; interview with DOC and other staff and review of home's policy "Narcotics and Controlled Drugs Management", reviewed March 31, 2023.
[506]

Date Remedy Implemented: August 24, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 271 (1) (b)

The licensee has failed to ensure that the approximate number of licensed beds at the home was posted on the home's website.

Rationale and Summary
The home's website did not have the number of licensed beds posted which was confirmed by the Executive Director (ED).
The ED acknowledged this was added to the website the next day.

Sources: Review of the home's website; interview with the ED. [506]

Date Remedy Implemented: August 24, 2023.

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 168 (2) 1.

The licensee has failed to ensure that the report under subsection (1) contained the name and position of the designated lead for the continuous quality improvement initiative.

Rationale and Summary
Review of the home's website did not include the name and the position of the designated lead for the continuous quality improvement initiated and this was acknowledged by the Executive Director (ED).
The website was updated to include the required information few days later.

Sources: Review of the home’s website; interview with the ED.[506]

Date Remedy Implemented: August 25, 2023

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary.

Rationale and Summary
A review of the resident’s plan of care identified that the resident required total assistance for all toileting needs with two staff and was not to be left unattended on the toilet.

The resident stated that they went to the toilet independently and did not require staff assistance.

Staff acknowledged that the resident was independent with toileting and that their plan of care should have been reviewed and revised to reflect the resident's current care needs.

Resident's plan of was later updated to reflect the resident' current toileting care need.

Sources: Resident's Clinical record; interview with staff and resident.[C205]

Date Remedy Implemented: August 24, 2023

WRITTEN NOTIFICATION: Plan of Care - When reassessment, revision is required

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs

change or care set out in the plan was no longer necessary.

Rationale and summary
A review of resident's plan of care identified that the resident required an adaptive device with cereals and soup.

Staff was observed feeding soup to the resident with a different device during lunch time.

The registered dietician (RD) acknowledged that the resident no longer required the adaptive device and that the resident's care plan should have been updated to reflect the resident's current nutrition care needs.

Sources : Resident's clinical record; meal observation; interview with RD. [C205]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure they complied with a procedure in their nutritional care and hydration program related to dietary services.

Rationale and Summary
In accordance with O. Reg. 246/22 s. 11 (1) b the licensee was required to ensure the nutritional care and hydration program had in place policies and procedures related to dietary services.

Specifically, staff did not comply with the Food Temperature Checklist which required dietary staff to check the food temperatures daily at the point of meal service.

During a lunch meal observation on a specified Resident's Home Area (RHA), the LTC Homes Inspector #C205 and #506 did not observe food temperatures being taken prior to the meal being served to the residents.

The cook acknowledged that they had not documented the temperatures in the menu software system.

The Nutrition Care Manager (NCM) acknowledged that staff did not follow their Meal Production Policy and should have checked the food temperature at the point of meal service and not only in the kitchen.

Sources: Meal observation; Food Temperatures Checklist (reviewed April 30, 2023) and Meal Production Policy (reviewed March 31, 2023); interview with the NCM and dietary staff. [C205]

WRITTEN NOTIFICATION: Food Production

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

The licensee has failed to ensure that planned menu substitutions were communicated to residents and staff.

Rationale and Summary
During an observation of the meal service, cream of broccoli soup was posted on the menu.

The dietary staff acknowledged that residents were being offered cream of asparagus and the menu board was not changed to reflect the substitution.

Sources: Meal observation; menu review and interview with dietary staff. [C205]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional

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Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection and application.

A staff was observed exiting a resident's room that was on additional precautions, requiring anyone entering to wear specific PPE. The staff was not wearing the required PPE.

The staff acknowledged that they had been providing personal care to the resident, and they that were not wearing the required PPE.

Failing to use the appropriate PPE posed a risk of spreading infection to other residents.

Sources: Observation of PSW staff; interview with staff. [506]