Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: January 4, 2024
Inspection Number: 2023-1043-0004
Inspection Type: Complaint Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Kilean Lodge, Grimsby

Lead Inspector	**Inspector Digital Signature**
Phyllis Hiltz-Bontje (129)	Phyllis Hiltz-bontje Digitally signed by Phyllis Hiltz-bontje Date: 2024.01.15 13:14:43 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24-27, 30-31, November 1-3, 6-9, 15, 27-30, December 4-6, 2023.

The following intake(s) were inspected:

- Intake: #00089395 -Critical Incident (CI) #1866-000004-23, related to prevention of abuse and neglect.
- Intake: #00090917 -CI #1866-000005-23, related to prevention of abuse and neglect.
- Intake: #00091150 -related to allegations of abuse, medication management and emergency plans.
- Intake: #00098825 -CI #1866-000012-23 - related to falls prevention and management.

The following intake was completed in this inspection:

- Intake: #00092308 -CI #1866-000007-23, related to falls prevention and management.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
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)

Non-compliance with: FLTCA, 2021, s. 85 (3) (c)

The licensee has failed to ensure the required information related to the licensee's prevention of abuse and neglect policy was posted in the home.

Rational and Summary

The Licensee's Resident Non-Abuse policy identified as ADMIN1-P10-ENT, last reviewed on March 31, 2023, was a three page document that made reference to a number of other documents that included: Mandatory Reporting of Abuse or Neglect, Investigation of Abuse and Neglect, Disciplinary action for Abuse or Neglect, Interventions for Victims of Abuse or Neglect, Toolkit for Conducting an alleged Abuse Investigation, Elder Abuse Supportive Resources and Types an Definitions of Abuse and Neglect.

The Fixing Long-Term Care Act and Ontario Regulations 246/22 set out the information that is required to be posted in the home related to the Prevention of Abuse and Neglect Policy.

The posted information related to the home's Resident Non-Abuse Policy did not include the required information when it was identified that the documents referenced in the home's policy had not been printed, included in the posted information and were available for viewing by residents, family members and visitors to the home.

The Executive Director confirmed the information referenced in the home's policy was not included in the posted information.

Remedy taken before conclusion of the inspection:

The Executive Director added the missing documents to the posting binder.

Sources: Resident Non-Abuse Policy, FLTCA 2022, O. Reg. 246/22 and interview with the ED.

Date Remedy Implemented: December 6, 2023.
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WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

a) The licensee has failed to ensure that a resident's right to be free from abuse was fully respected when they experienced abuse by a staff member.

Rational and Summary

A resident called staff for assistance with an activity of daily living. The staff responded in a loud tone and said they were busy and had other things to do.

The following day the resident reported the incident to another staff who contacted the Ministry of Long-Term Care's, after hours pager and reported the incident.

The home submitted a Critical Incident Report (CIR). The home updated the CIR with their conclusion that the incident had occurred.

Sources: CIS Report, and interviews with a staff and a resident.
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b) The licensee has failed to ensure that a resident's right to be free from abuse was fully respected and promoted when they experienced abuse by a staff member.

Rational and Summary

The home submitted a CIR. which identified that the resident had been abused by a staff member.

The resident told the Inspector that the staff member had made several negative comments that made them feel bad.
The Director of Care confirmed the incident occurred, and the home took action.

Sources: Critical Incident Report, and interviews with the resident, the staff and the DOC.
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WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of Care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the residents as specified in the plan.

a) The licensee has failed to ensure that care was provided to a resident as specified in their plan of care related to an activity of daily living (ADL).

Rationale and Summary

The resident's plan of care directed specific tasks that staff where to provide related to this ADL.

The resident told the Inspector they had not received assistance with their ADL because the staff told them they could do it themselves. The resident confirmed they did not receive care with this ADL.

The DOC confirmed the resident had not received the care as specified in their plan of care.

Sources: Resident's plan of care, an interview with the resident and the DOC. [129]

b) The licensee has failed to ensure that care was provided to a resident as specified in their plan of care related to a ADL.

Rationale and Summary

The resident's plan of care directed that the resident required support for an ADL due to their inability to complete the task safely, independently and were at risk for falling.

A staff member confirmed that the resident had told them that on the previous day they had called staff for assistance and were told they were too busy and to do the task by their self.

The resident told the Inspector they felt like they were a burden to the staff and were hesitant to call them again.

This resident was at risk for falling when staff had not provided care as specified in their plan of care.

Sources: Resident's plan of care, and interviews with the resident and staff.
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WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s.24 (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.

a) The licensee has failed to ensure a resident was protected from abuse by a staff member.

Rational and Summary

The resident told the inspector that a staff member raised their voice to them when they had called for assistance with an ADL. The resident said this made them feel like they were a burden, and they were hesitant to call for assistance again.

The resident's care plan at the time of the incident directed that the resident required support for this ADL, due to their inability to complete the task safely, independently, and were at risk for falling.

The following day the resident reported the incident to another staff who contacted

the Ministry of Long-Term Care's after-hours pager and reported the incident.

The home submitted a CIR that had determined the resident had been abused.

Sources: Resident's care plan, CIR Report, and interviews with the resident and staff.
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b) The licensee has failed to ensure a resident was protected from abuse by a staff member.

Rationale and Summary

A resident reported to management that a staff member made several negative comments about them, that made them feel bad.

The DOC and documents provided by the home, identified that it was determined that the resident had been abused by the staff and the home had taken action.

Sources: Licensee's investigative notes, a letter provided to the staff and interviews with the resident and the DOC.
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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee has failed to ensure that the Resident Non-Abuse Policy was complied with.

Rationale and Summary

The Licensee submitted a report to the Director, that identified a resident was abused by a staff member. Twenty-one days later, a second report was submitted to the Director, which identified that the same resident had been abused by a different staff member.

Licensees Resident Non-Abuse Policy/Program directed that "supports and referrals to professional resources would be offered to the resident, the resident would be monitored for any side effects and the investigation would be initiated following the guidelines in the Tool Kit, including obtaining written statements from the accused and any witnesses.

The DOC said they were unable to locate documentation to confirm the resident hand been offered supports or referrals to resources, that the resident was monitored for any side effects and confirmed they did not obtain written statements from the accused staff for both incidents.

The DOC confirmed the licensee's policy and procedures had not been complied with.

Sources: Critical Incident Report, Licensee's abuse policy and procedures, and an interview with the DOC.
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WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records

11. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place and plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,

(b) is complied with

The licensee has failed to ensure the required staffing plan was complied with.

Rational and Summary

Ontario Regulation 246/22, s. 11 (1) (b) directs that where the Act or the Regulation requires the licensee of a long-term care home to have or otherwise put in place and plan, the plan is complied with.

Ontario Regulation 246/22, s. 35 (2) requires every long-term care home to have a written staffing plan.

The licensee's required staffing plan identified a set number of staff who were required to work during a specified shift.

A resident verbalized that on a specified shift they had called staff for assistance. The staff responded they were too busy to assist them as they were short a staff member.

A staff member confirmed that on a specified date and shift a staff member was unable to report to work, had not been replaced and that the homes staffing plan was not complied with.

Non-compliance with the required staffing plan resulted in a resident not receiving assistance with their care needs.

Sources: Staffing plan and interviews with a resident and staff.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The licensee has failed to ensure a resident was administered a drug in accordance

with the directions for use specified by the prescriber.

Rational and Summary

A resident verbalized to the inspector and a staff member, that they had experienced specific symptoms and had asked staff for a specific drug. The staff responded that they were too busy, and the drug was not provided to the resident at that time.

A physician's order was in place for the resident that indicated they could have a specific drug for these symptoms.

The resident's Medication Administration Record (MAR) identified that the resident frequently received the prescribed drug when they had experienced symptoms in the past.

The current MAR confirmed that the prescribed drug had not been administered to the resident during the shift.

Sources: Resident Medication Administration Record and interviews with the resident and a staff member.

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