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

Original Public Report

Report Issue Date: June 17, 2024	
Inspection Number: 2024-1043-0001	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Kilean Lodge, Grimsby	
Lead Inspector Jennifer Allen (706480)	**Inspector Digital Signature**
Additional Inspector(s) Carla Meyer (740860) Jagmail Brar (000845)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): **May 27-30, 2024 and June 3-4, 2024.**

The following intake(s) were inspected:

- Intake: #00100434 - CIS #1866-000013-23 - Prevention of abuse and neglect.
- Intake: #00111730 - CIS #1866-000001-24 - Falls prevention and management.

The following intake(s) were complete in this inspection:

- Intake: #00104387 - CIS #1866-000014-23 - Fall prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's care plan provided clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident's plan of care included that floor mats were to be used as part of the fall prevention interventions which had previously been discontinued under the nursing fall risk focus of the resident's care plan. However, this intervention remained current under the Physiotherapy interventions as recommendations.

It was observed on specified dates in May 2024, that the resident did not have a floor mat on one side of their bed, but had one on the other. It was unclear who the floor mat belonged to as a staff stated that it was shared between the two residents residing in the room, however another staff acknowledged that the use of a floor mat was not on either one of the resident's care plans under the nursing interventions. A review of the resident's clinical records did not show documentation regarding the use of, or discontinuation of floor mats.

The Infection Prevention and Control (IPAC) Lead/Staff Educator acknowledged that if the use of the floor mat for the resident was discontinued, there should have been documentation to support this. The Physiotherapist (PT) acknowledged that floor mats were no longer required for the resident and should have been removed from their care plan.

On another specified date in May 2024, the PT informed the inspector that the resident's care plan had been updated.

Sources: Observations; review of resident clinical records and the home's policy titled, "Assessment and Care Planning, CARE1-P10" reviewed date March 31, 2024; and interviews with staff. **[740860]**

Date Remedy Implemented: May 30, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's care plan was revised when the resident's care needs changed.

Rationale and Summary
During observations on specified dates in May 2024, the resident was observed to be on bed rest. As per the resident's clinical records, this was part of their daily interventions. A staff confirmed that due to concerns; the resident is to remain in bed and only gets up on specific days.

The resident's care plan was reviewed with the IPAC Lead/Staff Educator and a staff who acknowledged that this intervention was not documented in the resident's care plan and that it should have been included.

A review of the resident's care plan on another specified date in May 2024, showed that this intervention had been added to the resident's care plan following the interview with the IPAC Lead/Staff Educator.

Sources: Observations; review of resident's clinical records and the home's policy titled, "Assessment and Care Planning, CARE1-P10" reviewed date March 31, 2024; and interviews with staff. **[740860]**

Date Remedy Implemented: May 27, 2024

WRITTEN NOTIFICATION: Nutrition and Hydration Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The Licensee failed to ensure that the Nutrition and Hydration Program's intervention to mitigate risk to the residents was implemented for a resident when a staff provided a substance that was not consistent with the resident's diet.

Rationale and Summary
A resident was noted to require a specified diet order. On an undisclosed date, a staff stated that they witnessed another staff provide food to the resident that was not according to their diet texture which was acknowledged by a registered staff.

The Executive Director (ED) acknowledged that the actions of the witnessed staff caused risk of harm to the resident.

Sources: Investigation package, resident's health records; interviews with staff.
[706480]

WRITTEN NOTIFICATION: Resident Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship,

creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident had their right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality respected.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director on a specified date in October of 2023, to report allegations of abuse. A staff stated that they witnessed an incident between a resident and another specified staff, where the specified staff did not respect the resident's choices, which caused the resident to exhibit behaviours. A staff and the ED stated that the resident had a known preference and that the specified staff also made comments to the resident.

Failing to ensure that the resident's rights to be treated with courtesy and respect in a way that fully recognizes the resident's inherent dignity, worth and individuality were fully respected and promoted, jeopardized the home's ability to care and communicate with the resident.

Sources: CIS # 1866-0000-13-23, LTCH internal investigation documents, Interviews with staff. **[706480]**

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 failed to ensure that their written abuse policy was complied with.

Rationale and Summary
Review of the home's Resident Non-Abuse Policy stated all staff have a duty to report any form of alleged, potential, suspected or witnessed abuse or neglect and anyone who becomes aware of, or suspects abuse or neglect of a resident must immediately report that information to the ED or, if unavailable, to the most senior supervisor on shift.

A CI report was submitted to the Director on a specified date in October of 2023, for allegations of abuse for two residents and several other incidents involving four other residents.

The ED confirmed that the home's internal investigation related to the alleged abuse was completed and that several other incidents were discovered that were not previously reported or documented at the time of those incidents occurring, involving the four residents. In which the incident with one of the resident was substantiated, and the actions of the staff towards the other three residents were not acceptable.

Failing to ensure that the home's Resident Non-Abuse Policy was complied with resulted in several additional incidents occurring having a negative impact on the residents.

Sources: CIS # 1866-0000-13-23, LTCH internal investigation documents, Resident Non-Abuse Policy, dated November 1, 2023; interview with staff. **[706480]**

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A CI report was submitted to the Director on a specified date in October of 2023, to report allegations of abuse of residents that resulted in a risk of harm. Within the CI report, a number of residents were identified. The originating incident was reported to the Director of Care (DOC) on a specified date in October of 2023. During the internal investigation and interviewing of other staff, additional incidents were uncovered. A specified staff was suspected of abusing a specified resident when they were witnessed by another staff. The LTCH completed an internal investigation and concluded that the witnessing staff did not report the incident to the management team or document the incident in the resident's medical chart. The ED indicated that the actions of the specified staff placed the resident at increased risk of harm. The ED and another staff indicated that the incident was never reported to the Director.

Failing to ensure that the allegation of abuse was immediately reported increased the risk of further incidences from the specified staff.

Sources: CIS # 1866-0000-13-23, LTCH internal investigation documents, Interviews with staff. **[706480]**

WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that available strategies were implemented to reduce or mitigate a resident's risk of falls.

Rationale and Summary

According to Ontario Regulations (O.Reg.) 246/22, s. 11 (1) (b), where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee is required to ensure that the program is complied with.

The home's policy titled, "Fall Prevention and Injury Reduction" last reviewed March 31, 2024 stated that in the case of a resident fall, strategies are put in place to prevent a further fall and reduce the risk of a fall-related injury.

A resident's clinical records indicated that on admission, they were assessed to be at risk for falls.

On a specified date in March of 2024, the resident fell, was re-assessed and their level of fall risk was changed. Their fall prevention interventions implemented after this fall only included the use of proper footwear and increased monitoring.

On another specified date in March of 2024, the resident had another fall resulting from a similar situation that caused the first fall. The resident was subsequently transferred to the hospital where they were diagnosed with an injury.

Interview with the home's PT, a staff, and the home's Falls Program Lead acknowledged that the use of an alarm should have been implemented after the resident's first fall as part of the home's falls prevention strategies.

By not implementing the use of an alarm after the resident's first fall incident resulting in a change of level of fall risk, and as part of the home's available falls prevention strategies, the resident's risks for falls may not have been properly mitigated.

Sources: Observations; interview with the home's staff, and review of the resident's clinical records, and the home's policy titled "Fall Prevention and Injury Reduction" last reviewed March 31, 2024. **[740860]**

COMPLIANCE ORDER CO #001 Duty to Protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Provide education for all Registered Staff and Direct Care Staff on:

- The definition and meaning of abuse; and
- Zero tolerance of abuse; and
- FLTCA 2021, s. 3 (1) 1, Resident Bill of Rights, and
- What to do if there is suspicion of any form of abuse, and
- The process for how to respond to alleged, suspected, or witnessed abuse of residents, including the requirement to comply with mandatory reporting.

2) Document the education, including the date it was held, the staff members who attended, and the staff's signatures that they understood the education. Also include who provided the education; and

3) Each staff member who attends training is to complete a written assessment, developed by and deemed appropriate by the LTCH, that reflects understanding of the training material related to abuse prevention; and

4) The home must keep a record of the education and assessment material for the LTCH inspector to review.

Grounds

The Licensee failed to ensure that two residents was protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Section 2 of the O. Reg. 246/22 defines "emotional abuse" means as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CI report was submitted to the Ministry of Long-Term Care (MLTC) for several incidents where the actions of a specified staff were identified as a potential concern.

A. On a specified date in October of 2023, a staff stated that a specified staff reported to them that they had an interaction with a resident when they became offended and upset when the resident made comments about their size and where they were from. During that reported interaction the specified staff stated they approached the resident and confronted them about their comments. The staff stated that later that same day, the resident questioned if the specified staff was offended by something they had said. The staff stated that the specified staff was confrontational again to question the resident why they had talked about them in a hostile tone. The staff felt that confronting the resident twice was not an acceptable behaviour of the specified staff. The ED stated that the resident was upset following the first and second interactions. According to the CI investigation interview, the specified staff was increasingly confrontational with the resident during the multiple interactions. The ED during the investigation substantiated that the actions of the specified staff was not appropriate towards the resident and that they were impacted.

Sources: CIS #1866-000013-23 investigation package, resident's health record and progress notes, interviews with staff.

B. On a specified date in October of 2023, a resident had requested assistance from a specified staff, when they were told they were busy, and the resident had to wait. The resident continued to request for assistance and was becoming agitated. Upon direction from a registered staff, another staff eventually assisted the resident and noted that the resident appeared very upset.

After the resident received assistance, the other staff was stopped by the specified staff from continuing to help the resident so that they could take over the care and see what the resident had to say about them. Following the last encounter with the specified staff, the resident was visibly upset and displayed behaviours that was not their usual. The ED stated the actions of the specified staff towards the resident constituted abuse due to the resident being noticeably affected by the encounter and staff noticed an obvious change in the resident's behaviour following the encounter.

The ED acknowledged that the investigation conducted by the home into the incidents and actions of the specified staff was substantiated as abuse.

Failure to protect the residents from abuse, led to harm and risk of harm to the resident's sense of well-being.

Sources: CIS #1866-000013-23 investigation package, resident's health record, interviews with staff. **[706480]**

This order must be complied with by August 2, 2024.

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.