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

Public Report

Report Issue Date: December 4, 2024

Inspection Number: 2024-1043-0002

Inspection Type:
District Initiated
Critical Incident
Follow up

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Kilean Lodge, Grimsby

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5-8, and 12, 2024.

The following intake(s) were inspected:

- Intake: #00116344 -Critical Incident 1866-000003-24 - related to prevention of abuse and neglect.
- Intake: #00118961 - Follow-up #: 1 - CO #001/2024_1043_0001, FLTCA, 2021, s.24 (1) Duty to protect. CDD August 2, 2024.
- Intake: #00130701 - related to infection prevention and control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1043-0001 related to FLTCA, 2021, s. 24 (1)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (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 has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary:
a) At an observed lunch meal, a resident was not positioned safely while being assisted with eating. The resident's plan of care directed staff to position the resident in a certain way.

During interview, a registered staff member stated that the position identified in the resident's plan of care was not appropriate for the resident.

The home's Registered Dietitian (RD) stated that the positioning directions identified in the resident's plan of care were based on previous recommendations and the plan of care should have been revised to reflect the resident's current needs.

Sources: observations in the dining room; interview with staff; the clinical health record of a resident, including their care plan.

b) The plan of care for a resident directed staff to use an assistive device when the resident was in their wheelchair. At an observed meal, the resident was observed in their wheelchair without the assistive device.

Registered staff stated that the intervention was no longer required for the resident's wheelchair and acknowledged that the plan of care was not revised when the resident no longer required the intervention.

Sources: observations in the dining room; interview with registered staff; clinical health record of a resident, including the resident's plan of care.

When the plan of care is not revised when the resident's care needs change or are no longer necessary, there is a risk that staff will provide care that is not consistent with the resident's current needs and wishes.

Date Remedy Implemented: November 12, 2024

WRITTEN NOTIFICATION: Nutritional care and hydration programs

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

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure that the nutrition and hydration programs included the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration.

Rationale and Summary:

Two staff stated that the home changed the way their policy for monitoring residents during meals and snacks was implemented as a result of a critical incident submitted to the Ministry of Long-Term Care.

The home's Registered Dietitian stated that they were not involved in the development of the home's policy related to monitoring of residents during meals and snacks or discussions about changes in the way the policy was implemented.

When the home's Registered Dietitian was not included in the development and implementation of the home's nutrition related policies, the policies may not be consistently interpreted and implemented.

Sources: interview with staff, policies related to Meal Service and Tray Service Guidelines for Meals.

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (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:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

Rationale and Summary:
At an observed meal service, staff did not safely position a resident when they were being assisted with eating. The resident was at nutritional risk and required an altered texture meal.

The resident's plan of care directed staff to ensure the resident was in a certain position during feeding. The Registered Dietitian (RD) confirmed the resident was at nutritional risk and stated the resident needed to be in a certain position for safety while being assisted with eating.

When a resident is not safely positioned while being assisted with eating there is increased risk for respiratory complications.

Sources: dining room observation; interview with staff; clinical health record for a resident, including the resident's plan of care.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, was implemented.

Rationale and Summary:
The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 f), that the licensee shall ensure that Additional Precautions were followed in the IPAC program, including appropriate selection application, removal and disposal of personal protective equipment (PPE).

Signage on the wall outside an identified room directed staff to provide additional precautions when providing care to a resident.

A staff member was observed providing care to the resident. The staff confirmed the resident required additional precautions and acknowledged that they provided care without wearing all of the required personal protective equipment (PPE).

A Nurse confirmed that staff did not wear the appropriate PPE while providing care to the resident.

When staff do not follow the required additional precautions, there is risk of

transmitting infections to staff and residents.

Sources: observations; interview with staff.