Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 16, 2013	2013_105130_0001	H-00581-12	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 6, 2012

During the course of the inspection, the inspector(s) spoke with The Executive Director, Registered Staff, personal support workers and residents related to H-000581-12.

During the course of the inspection, the inspector(s) Interviewed staff, residents, observed meal service and reviewed clinical records.

Ad-hoc notes were used during this inspection.

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. The plan of care for resident #1 indicated the resident required extensive assistance with eating. In 2012, during a meal, the resident was served an entree and waited for a period in excess of 30 minutes, for assistance to be provided. Staff verified the resident does not eat without assistance. [s. 6. (7)]

2. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective. The plan of care for resident #2 indicated the resident required set up assistance at meals and cueing to swallow. In 2012 the resident was observed over a meal service. The resident was served an entree and not offered assistance for approximately 30 minutes. The resident did not attempt to eat the meal and staff interviewed confirmed the resident will not eat without assistance from staff. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system are prepared, stored and served using methods to (b) prevent adulteration, contamination and food borne illness.

In 2012, the inspector observed staff carrying trays of food (designated for residents) up stairwells to dining rooms on 1st and 2nd floors. The trays contained foods on paper plates which were not covered or protected in any way from potential contamination. Staff have a contingency procedure and the availability of proper plates (not paper) and plate covers for the manual transport of foods when a steam table cannot be used due to an elevator failure. [s. 72. (3) (b)]

WN #3: 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. (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 did not ensure that the home had a dining and snack service that included, at a minimum the following: that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident. In 2012, during the supper meal service resident #1 and #2 were served entrees at approximately 1700hours and not offered assistance with the meal for a period greater than 30 minutes. Staff interviewed confirmed that both residents required assistance with eating. [s. 73. (2) (b)]

Issued on this 16th day of January, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Gillian Tracey