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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2019	2019_756583_0003	024517-17, 001584-18, 002940-18, 019532-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

KELLY HAYES (583), CATHIE ROBITAILLE (536)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 23, 24, 25, 28 and 29, 2019.

The following Critical Incident System (CIS) Inspections were completed:

Log # 024517-17, related to alleged staff to resident neglect.
Log # 001584-18, related to an injury of unknown cause.
Log # 002940-18 and #019532-18, related to improper/incompetent treatment of a resident that resulted in harm or risk of harm to a resident.

During the course of the inspection, the inspector(s) spoke with Executive Director/Director of Care (ED/DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Physiotherapy assistant (PTA), Personal Support Workers (PSW) and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. Under the personal support services program, where staff used an assistive aid with respect to a resident, the licensee failed to ensure the assistive aid was appropriate for the resident based on the resident's condition.

A) Critical Incident # 1866-000011-18, log #019532-18, submitted in 2018, described an incident where resident #004 received improper care which resulted in risk to the resident.

The homes investigation notes and the resident's clinical records were reviewed. The home's investigation notes identified an assistive aide was provided by PSW #115 to assist the resident. An incident occurred where resident #004 was in a compromised situation which put the resident at risk. In an interview with PSW #115 in January 2019, it was confirmed at the time of the incident the staff used an assistive aide that was not based on the residents condition.

The resident was assessed at the time of the incident and no injuries were identified.

Resident #004's care plan interventions, and assessments were reviewed and it was identified at the time of the incident an assistive aide was used that was not the same as what was directed in the resident plan of care.

In an interview with the ADOC in January 2019, it was confirmed that the assistive aid used to assist resident #004 on the date of the incident, was not an appropriate assistive device to use based on the resident's assessed condition.

B) Critical Incident #1866-000002-18, log #002940-18, submitted in 2018, described an incident where resident #003 received improper care which resulted in harm to the resident.

The homes investigation notes and the resident's clinical records were reviewed. The home's investigation notes identified an assistive aide was provided by PSW #103 to assist the resident. An incident occurred where resident #003 was in a compromised situation which resulted in an injury to the resident.

Resident #004's care plan interventions, and assessments were reviewed and it was identified at the time of the incident an assistive aide was used that was not the same as what was directed in the resident plan of care. This was was also confirmed during a review of the home's investigation documents and through an interview with PSW #003.

In an interview with the Physiotherapist in January 2019, it was confirmed that at the time of the incident resident #003 only used the assistive aide that PSW #103 used for therapy and front line staff were supposed to use the another identified aide for care as directed in the plan of care.

In an interview with the ADOC in 2019, it was confirmed that the assistive aide used to assist resident #003 on the date of the incident, was not an appropriate assistive device to use based on the residents assessed condition. [s. 30. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure where staff used an assistive aid with respect to a resident, the licensee ensures the assistive aid is appropriate for the resident based on the resident's condition, to be implemented voluntarily.

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.