Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 1, 2019	2019_820130_0009	012140-19	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

GILLIAN HUNTER (130)

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): October 18, 21, 22, 23, 24, 28, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed residents, reviewed relevant resident clinical records, investigation notes, critical incident reports and relevant meeting minutes.

This inspection was conducted related to the following intake:
- Log # 012140-19 related to falls prevention and management.

PLEASE NOTE: This CI inspection was conducted concurrently with a Complaint inspection # 2019_820130_0008.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Associate Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, the Office Manager/Food Services Manager (FSM), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

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 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).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care for resident #003 was provided to the resident as specified in the plan.

According to the plan of care, resident #003 demonstrated an escalation of responsive behaviours and required a specific intervention put in place, commencing on an identified date in 2019.

The ADOC confirmed that the specific intervention was to be provided during specific hours.

Critical incident #CI 1866-000011-19 , submitted in June 2019, described an incident, where on an identified date in 2019, resident #003 sustained a fall resulting in an injury.

The post fall assessment confirmed the fall was not witnessed. It was confirmed in the CI and interview with RPN #107 and the ED, that the specific intervention that was to commence on an identified date was not in place at the time of the fall, as specified in the plan of care.

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 that care set out in the plan of care for resident #003 is provided to the resident as specified in the plan., to be implemented voluntarily.

Issued on this 1st day of November, 2019

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

Original report signed by the inspector.