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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date **September 29, 2022**
Inspection Number **2022-1043-0001**
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ____________________

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

Long-Term Care Home and City
Kilean Lodge
83 Main Street East Grimsby ON L3M 1N6

Lead Inspector
Jennifer Allen (706480)

Inspector Digital Signature

Additional Inspector(s)
Klarizze Rozal (740765)

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 1, 2, 6, 7, 8, 9, 12, 13, 14, 15, 2022

The following intake(s) were inspected:

- Intake # 015456-22 (CI:1866-000009-22) related to abuse and neglect
- Intake # 016422-22 (CI:1866-000012-22) related to abuse and neglect
- Intake # 021092-21 (Complaint) related to abuse and neglect
- Intake # 021073-21, (Follow-up) related to safe transferring and positioning

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 36	2021_943988_0005	001	Jennifer Allen (706480)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be **CLOSED**.

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Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
Choose an item.				
Choose an item.				

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

- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were findings of non-compliance.

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)

FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care for a resident had clear directions in regards to specific wound treatment.

A resident had two different treatment orders as specified in their plan of care. One order gave clear direction and the second order did not specify a specific location where the treatment was to be applied.

A registered staff member confirmed that the plan of care indicated one treatment was not specific to where the treatment was to be applied. A registered staff member corrected that order to specify the location for the treatment and they communicated the change in treatment to the other staff. Later the same day, it was confirmed the treatment order was updated and applied correctly.

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The risk to resident's wound healing was low by performing the incorrect treatment.

Sources: Observations, resident electronic medical records (EMR), and interview with registered staff.

Date Remedy Implemented: September 14, 2022 [#740765]

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

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

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

The licensee failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

Rationale and Summary

The Power of Attorney (POA) of a resident issued a complaint to Director of Care (DOC) about their concerns of neglect with wound care. A Critical Incident System (CIS) report was submitted by the home in response to the complaint.

According to the DOC, they initiated the CIS report and believed the report was submitted on the date the complaint was received. However, due to procedural misunderstanding, the CIS report was not submitted until seven days later. The CIS report was saved but was not submitted successfully through the CIS reporting portal. Therefore, this was not received by the Director on the date the home became aware of the complaint.

The DOC confirmed that reporting to the Director for alleged abuse or neglect and outlined in their home's policy was to be done immediately.

Sources: CIS Report, Mandatory Reporting of Resident Abuse or Neglect Policy, investigation documents, emails, resident electronic medical records (EMR), and interview with the DOC.

[#740765]

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.