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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 9, 2014	2014_293554_0038	O-001140-14	Resident Quality Inspection

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

KENNEDY LODGE
1400 KENNEDY ROAD SCARBOROUGH ON M1P 4V6

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

KELLY BURNS (554), AMBER MOASE (541), HUMPHREY JACQUES (599), KARYN WOOD (601), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 24-28, 2014 and December 01- 03, 2014

During this Resident Quality Inspection(RQI), the following concurrent intakes were completed: #T-000751-14, T-000811-13, T-000812-13, T-000813-13, T-000865-14, T-000891-14, T-000909-14

During the course of the inspection, the inspector(s) spoke with Executive Director, of Care, Assistant Director of Care(s), Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Environmental Services Manager, Housekeeping Aide, Activity Program Aide(s), Physiotherapist, Social Worker, RAI Coordinator, RAI Assist, Physician, Residents, Family

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
3 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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Related to Resident #31:

The licensee failed to comply with LTCHA, 2007, s. 6 (1)(c), by ensuring that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

During an interview Resident #31's family member indicated that the home had removed the bed rails from resident's bed; the family member commented that no one from the home had contacted the family as to why the bed rails were removed. Family voiced further concern that the plan of care had been changed without their input.

Resident #31 indicated that the bed rails were used to assist with bed mobility; resident commented that the bed rails were removed without resident's input. Resident was unsure why the bed rails were removed and voiced displeasure with the removal.

The written plan of care, in place at the time of the inspection, indicated that Resident #31 utilizes the bed rail(s) for bed mobility.

Staff #119 recalls that bed rails were in place for Resident #31 on an identified date, but when staff returned to work the next day the bed rails had been removed from resident's bed. Staff indicated no awareness of why the bed rails had been removed.

Staff #120 who works on the unit where Resident #31 resides indicated no awareness of why the bed rails were removed.

Staff #121 indicated that members of nursing administration had given instructions for the bed rails to be removed from beds located on the resident home area. Staff #121 commented being unsure as to why the bed rails were to be removed.

During an interview, the Assistant Director of Care indicated that an assessment had been completed and it was determined that Resident #31 did not require bed rails; the Clinical Manager indicated that family were informed at a care conference that bed rails were not required for Resident #31.

A review of Resident #31's clinical health record failed to provide supporting documentation of a discussion with family specific to bed rails.

The Director of Care was in agreement that the written plan of care had not been updated to reflect the change nor was there supporting documentation of discussions with family or resident. [s. 6. (1)]

2. Related to Log #T-000909-14 for Resident #43:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care provided was the resident as specified in the plan.

The Director of Care, submitted a Critical Incident Report indicating the following details:

On a specific date, Resident #43 was found lying on the ground outside the home.

According to documentation Resident #43 was last observed approximately two hours prior to being located outside the home.

The written plan of care for Resident #43 indicated the following:
- Resident is a safety risk due to responsive behaviours
- Hourly safety checks
- Staff are responsible to check and ensure the safety device, located on resident's chair, is on and working at all times

The Director of Care, in an interview, indicated Resident #43 had exited the home and that the door alarms didn't alert staff because the resident's safety device was not attached to the resident's chair.

The homes investigation notes identified that the day prior to the incident, the assigned staff had noticed that the safety device was not in place for Resident #43 and communicated this concern to two registered nursing staff.

Staff #112, who was assigned to care for Resident #43 the day of the incident indicated that hourly safety checks were not performed for this resident during an identified time period.

The Executive Director and the Director of Care indicated it is the home's expectation that if a resident has been identified at safety risk the Personal Support Worker is responsible to complete hourly safety checks and to complete the required documentation. [s. 6. (7)]

3. Related to Log #T-000811-13, for Resident #47:

The licensee failed to comply with LTCHA, 2007, s. 6 (11)(b), by ensuring that when the resident was reassessed and the plan of care was being revised because the care set out in the plan was not effective, that different approaches were considered in the revision of the plan.

Review of the progress notes for Resident #47 since admission indicated resident as having had numerous falls; one fall resulted in injury:

The majority of the falls were when the resident had climbed out of bed while side rails were up.

The Physiotherapist(PT) recommended the resident's bed should be kept in the lowest

position, call bell within reach and monitored regularly when in bed. PT indicated "resident usually climbs out of bed" and recommended "bed sensor and regular monitoring by staff for safety when in bed".

Review of the plan of care for Resident #47 indicated the resident was at high risk for falls. Interventions included: bed to be kept at lowest position and locked, bed/chair sensor, floor mattress used, communicate fall risk to staff, ensure call bell is attached to clothes, ensure that basic needs are met (i.e. hunger, elimination, comfort).

Review of care plan (during another time period) for Resident #47 indicated the resident was at high risk for falls related to Falls Risk Assessment,previous falls and or injury, impaired cognition, attempts to get out of bed unassisted, impaired mobility and discomfort. Interventions included: falling star logo used to identify falls risk, bed kept at lowest position and locked when resident in bed, fall mat in place when in bed, bed sensor/chair alarm is used, explain and demonstrate each activity procedure prior to beginning and throughout procedure.

Review of the home's "Fall Prevention & Harm Reduction Strategies" policy indicated environmental strategies included 1/4 rail Arco rail.

The revisions to the care plan did not consider different approaches such as recommendations by physio for frequent monitoring of the resident when in bed, despite the resident climbing out of the bed or around side rails that were kept in the upright position, and the falling star logo was not implemented until after the resident sustained an injury from the last fall. [s. 6. (11) (b)]

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 there is a process in place to monitor that the care set out in the plan of care is provided to the resident(s)as specified in the plan; and when a resident is reassessed and the plan of care reviewed and revised, because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2)(c), by ensuring the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during the inspection:

- Walls – scuffed (black marks), scratches and or wall damage in room(s) #102, 108, 110, 111, 115, 117, 118, 124, 125, 127, 129, 130, 200, 201, 202, 208, 210, 211, 216, 220, 222, 223, 226, 238, 311, 318, 330

- Door Frames – scuffed (black marks), scratched and or damaged in room(s) #102, 108,

111, 118, 122, 126, 127, 132, 200, 208, 211, 220, 223

- Floors – tiles cracked or broken in room(s) #102, 111, 122, 125 and on the 2nd Floor hallways by south fire doors

- Baseboard/Wall Guard – loose or missing in room(s) #111, 115, 202, 234, 238

- Spa Rooms – North, Main (1st), 2nd and 3rd – laminate flooring split/cracked in areas throughout the room(s); flooring is wet in areas and seeping into sub-flooring; (this poses an infection control issue)

- Spa Room – North Main (1st) – cupboard in room has laminate chipped and or missing in areas (this is a porous surface which poses an infection control risk)

- Sink – chipped in areas in room(s) #125

- Sink Vanity – laminate surrounding sink in the is missing or damaged in resident washrooms in room #111, 222

- Ceiling – damaged or water stains visible in room(s) #108, 111, 118, 223

- Washroom Vent – soiled with thick grey dust in room #223

- Toilet and Toileting Grab Bars – loose in room #236 (issue has been resolved)

- ARJO Sit to Stand Lift (two) on the second floor – frame (legs) were scraped and rusted in areas

The Physical Plant Service Requisition booklet was reviewed for a specific time period, work requisitions in this booklet failed to identify the above maintenance repairs required on the identified home area.

Environmental Services Manager indicated awareness of some of the above maintenance issues requiring repair, but confirmed that not all areas had been identified as requiring repair and or maintenance.

The Executive Director was in agreement that there are some areas of required maintenance repairs needed throughout all resident home areas. [s. 15. (2) (c)]

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 there is a process in place and monitored to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. Related to Log #T-000909-14 for Resident #43:

The licensee failed to comply with O. Reg. 79/10, s. 55 (b), by ensuring that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

A Critical Incident Report was submitted by the Director of Care, details of the CI are as follows:

Resident #43 fell outside of the home. The home initiated an investigation, which concluded staff had failed to check on the resident for approximately two hours.

The written plan of care identifies Resident #43 as being at safety risk due to known responsive behaviours.

Staff #115 indicated that Resident #43 was exhibiting responsive behaviours hours prior to the incident and indicated a specific time when the resident was last observed. Documentation in the health record confirmed Staff #115's observation.

Staff #112, who was working the shift when the incident occurred, indicated that shift report was not provided, to the oncoming staff, the day of the incident; staff further indicated not being aware that Resident #43 was exhibiting responsive behaviours increasing which placed resident at increased safety risk.

Director of Care indicated that staff are to be provided with a shift to shift report at the beginning of each shift and changes in residents are to be communicated at that time.

The Executive Director and the Director of Care confirmed that it is the home's expectation that if a resident has been identified as a safety risk the Personal Support Worker assigned is responsible to complete hourly safety checks and complete documentation in the electronic documentation record. [s. 55. (b)]

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 there is a process in place and monitored to ensure that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 5, by ensuring that the home is a safe and secure environment for its residents.

The following observation was made:

During the initial tour of the home, an inspector observed the door to the laundry chute door was closed but unlocked and opened easily. The unlocked laundry chute door identified above was located on a specific resident home area. (Note: no residents were visible in this area during the time of the observation)

Staff #124 present during the time of the observation indicated that the door normally locks automatically when the door is closed tightly. Staff #125 opened and closed door demonstrating that the lock on the door did work when the door was pulled closed.

Environmental Services Manager indicated that the laundry chute door was assessed on the date in which issue was identified and adjustments to the closure made to ensure area safe. [s. 5.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 14, by ensuring that each resident shower has at least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

The following was observed:

- Spa Room – Main (1st) Floor, North – no shower grab bar located on same wall as the faucet

- Spa Room – Second Floor, North – no shower grab bar located on the same wall as the faucet

- Spa Room – Third Floor, North – no shower grab bar located on the same wall as the faucet nor on the adjacent wall

The Director of Care and the Environmental Services Manager both indicated no awareness of the requirements for shower grab bars and or related placement of the same.

On the date identified, the Environmental Services Manager and the Director of Care were making arrangements for shower grab bars to be installed. [s. 14.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The following observation was made:

- 1st Floor (Main), Room #111 could be opened greater than fifteen centimetres. The window could be opened approximately thirty-three centimetres; this is a second storey window. The window was closed at the time of the observation.

Director of Care was made aware of the safety concern specific to the window opening; DOC indicated that the window would be immediately attended too.

Environmental Services Manager indicated no awareness of the window opening greater than 15 centimetres.

The window opening in the identified room was in compliance with the legislation within an hour of the concern being reported to the home. [s. 16.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Related to Log #T-000891-14:

The licensee failed to comply with O. Reg. 79/10, s. 107 (4), by ensuring that the written report included a description of the individuals involved in the incident, including the names of any residents involved in the incident.

A Critical Incident Report was submitted, by the Assistant Director of Care, for a fall resulting in transfer to hospital. The CIR indicated Resident #16 fell during two specific time periods; according to the CIR, both incidents required registered nursing staff to monitor resident as directed by the home's policy. CIR indicated resident's condition began to deteriorate, and a decision was made to transfer resident to hospital for further assessment.

Review of the health care record for Resident #16 indicated resident had no documented evidence of a fall during the dates in which the home indicated. The health record for this resident did not indicate resident's health deteriorating nor requiring the need hospitalization.

According to home's Risk Management Incident records, the only resident to have had a fall during the identified time period was Resident #41, whose date of birth and substitute decision maker is consistent with the Critical Incident Report submitted by the Assistant Director of Care.

Assistant Director of Care indicated that the Critical Incident Report submitted had the incorrect resident name identified on the submission.

As of the date of this inspection, no amendments had been made by the Assistant Director of Care or other representative specific to resident's name. [s. 107. (4) 2.]

2. Related to T-000811-13:

A Critical Incident Report was submitted for a fall resulting in transfer to hospital. The CIR indicated Resident #47 was found on the floor in the resident's room and had sustained injury.

Review of the health care record for Resident #47 indicated the resident had no documented evidence of a fall during the time indicated.

Interview of the ADOC (who completed the CIR) indicated that the CIR had an incorrect resident's name indicated on the CIR. [s. 107. (4) 2. i.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by ensuring that all staff participate in the implementation of the infection prevention and control program.

The following observations were made:

- Basins were observed on the washroom floors, beside the toilet, in room(s)#108 (one), 117 (three), 124 (two); all rooms identified are shared resident rooms.

- Specimen collection devices were observed behind the toilet, on the floor, in resident shared washrooms in room(s) #118, 126, 130; a specimen collection device was hanging on the wall beside washbasins in room #115. All items were noted to be soiled.

- A bedpan was observed sitting on the back of the toilet in room #126; this is a shared (semi) washroom. The bedpan was soiled and not labelled for individual resident use.

- A urinal was observed sitting on top of a dresser in room #132; the urinal contained pale yellow fluid. The urinal was unlabelled. This is a shared (ward) resident room.

The Assistant Director of Care indicated that specimen collection devices are not to be stored in resident washrooms; ADOC commented that these devices are for one time use only and should be disposed of following use.

Assistant Director of Care and Director of Care indicated that wash basins are not to be stored on resident washroom floors but are to be kept on hooks in the washroom; both indicated bedpans and urinals are to be labelled for individual resident use and to be stored in resident's bedside table. [s. 229. (4)]

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

Issued on this 10th day of December, 2014

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

Kelly Burns (554)

Original report signed by the inspector.