Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux 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 16, 2020	2020_780699_0018	021711-20, 021883-20	Complaint

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

Kennedy Lodge
1400 Kennedy Road SCARBOROUGH ON M1P 4V6

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

PRAVEENA SITTAMPALAM (699)

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): November 09, 10, 2020.

The following complaint intakes were inspected:

-Log 021711-20 related to resident care concerns; and
-log 021883-20 related to infection prevention and control measures in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Regional Manager, Nutrition Manager, Programs Manager, registered nurses (RN), personal support workers (PSW) and program aides.

During the course of the inspection, the inspector conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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 has failed to ensure that the home was a safe and secure environment for its residents.

The Ministry of Long-term Care (MLTC) received a complaint regarding staff serving outside food to other residents despite the home being on outbreak. A resident's family provided the home a store bought food item. The resident was pictured in front of the food which was uncovered, less then six feet away, with no mask on. The food item was subsequently served to residents on the floor by the recreation team. The unit where the resident was residing had two confirmed cases of a specified infection and droplet contact precautions were in place home wide. Staff confirmed that there was a risk of droplet transmission of the specified infection as the resident was sitting in front of the food with no mask on.

Sources: Interviews with Recreation Manager #102, ED #100, and a picture of a resident. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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 has failed to ensure that two residents who required assistance with eating or drinking were only served when someone was available to provide them assistance.

The MLTC received a complaint alleging residents were not being assisted with their meals, resulting in residents not eating. The inspector conducted observations on November 09, 2020, during lunch time. Two residents were served trays and left on their bedside table. Approximately after ten minutes the residents were served their lunch, staff went into their rooms to provide them with assistance. The PSWs were serving all the residents their trays and then going to assist residents who required assistance due to the current outbreak in the home. Staff confirmed that the residents should not have been served unless assistance was available and that the meals would not be kept warm if the meal was served after ten minutes.

Sources: Observations, and interviews with PSW #101, Nutrition Manager #103 and ED #100. [s. 73. (2) (b)]

Issued on this 17th day of November, 2020

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

Original report signed by the inspector.