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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2017	2017_530673_0013	023441-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 24, 25, 26, 27, 30 & 31, 2017.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), PSW students, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Food Service Supervisor (FSS), Registered Dietician (RD), and Social Service Coordinator (SSC).

During the course of the inspection, the inspector(s) conducted a tour of the home, observed staff and resident interactions and the provision of care, reviewed health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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	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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

During stage one of the Resident Quality Inspection (RQI), a room observation revealed that resident #006 had medications and an ointment stored at his/her bedside.

In an interview, staff #110 stated that the medications had been in resident #006's medication pouch on a specified date in October 2017, and that he/she had administered them to resident #006 at the prescribed time. Review of the medication pouch strip for the next day revealed the medications were not included in the pouch.

In a follow-up interview, staff #110 stated he/she had assumed the medications had been in the medication pouch, acknowledging that he/she had not complied with the home's policy related to the eight rights of medication administration and therefore had not administered the medications to resident #006 in accordance with the directions for use as specified by the prescriber.

In an interview, staff #126 stated he/she had worked on two specified dates in October 2017, and had signed that the medications had been administered to resident #006 at a specified time. Staff #126 further stated he/she had not actually observed resident #006 self-administer and therefore he/she had not administered the medications in accordance with the directions for use as specified by the prescriber.

In an interview, staff #101 acknowledged that the home failed to ensure that the medications had been administered in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During stage one of the Resident Quality Inspection (RQI), a room observation revealed that resident #006 had medications and an ointment stored at his/her bedside.

In an interview, resident #006 stated he/she had been independently self-administering the identified medications, and that he/she had not informed the home's staff. Resident

#006 further stated that he/she normally takes the medications at a specified time.

Review of resident #006's health record and electronic medication administration record (e-MAR) did not reveal physician orders for any of the above mentioned medications. Further review of resident #006's health record revealed that physician's orders were obtained after the inspector's observations.

In an interview, staff #108 stated that an assessment of resident #006's cognitive abilities had been completed and signed by resident #006 and staff #108 indicating that resident #006 understood the agreement.

In an interview, staff #101 acknowledged that resident #108 had been taking medications without a physician's order therefore, the home had failed to ensure that no drug is used by a resident in the home unless the drug has been prescribed for the resident. [s. 131. (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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

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Issued on this 1st day of December, 2017

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

Original report signed by the inspector.