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 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 30, 2019	2019_767643_0016	008646-18, 009923-18, 012048-18, 012773-18, 017378-18, 027233-18, 030125-18, 002231-19	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

Kennedy Lodge
1400 Kennedy Road SCARBOROUGH ON M1P 4V6

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

ADAM DICKEY (643), BABITHA SHANMUGANANDAPALA (673)

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): May 13-17, 21 and 22, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #008646-18; CIS #2654-000006-18 and Log #017378-18; CIS #2654-000017-18 - related to alleged abuse; and
Log #009923-18; CIS #2654-000011-18, Log# 012048-18; CIS #2654-000014-18, Log #012773-18; CIS #2654-000015-18, Log #027233-18; CIS #2654-000028-18, Log #030125-18; CIS #2654-000032-18 and Log #002231-19; CIS 2654-000001-19 - related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Physiotherapist (PT), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Workers (SW), Local Health Integration Network (LHIN) representatives, residents and family members.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

a. A CIS was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to resident #001 who sustained an injury on an identified date, which resulted in a transfer to hospital and experienced a significant change in their health status.

A review of the home's investigation notes, including staff interviews, could not substantiate the cause of the injury; however, a review of resident #001's Fall Risk Screen assessment from an identified date showed the resident had been assessed to be at risk for falls. Further review of resident #001's assessments, showed a history of six unwitnessed falls over a five month period.

A subsequent falls risk screen was conducted following the sixth above mentioned fall showing an increased falls risk. An interdisciplinary team huddle was also conducted and a new specified falls prevention intervention was initiated.

Review of PT #113's recommendations found in post fall assessments, clinical and order listings for resident #001 included frequent and increased monitoring for safety and fall prevention after each fall. After two specified falls in the first month of the above five month period, PT #113 also recommended implementation of a scheduled toileting plan for resident #001.

Review of resident #001's written care plans which were in place over the above five month period, showed frequent monitoring as a falls intervention. Review of point of care (POC) documentation from the five month period, did not show a revision in the tasks related to monitoring, or a toileting schedule for resident #001.

In an interview, PSW #115 did not identify toileting as a falls intervention for resident #001, and indicated that they were assisted with toileting at specified times before and after mealtimes on their scheduled shifts.

In an interview, ADOC #117, who was the falls program lead, indicated that falls interventions included scheduled toileting for residents who were falling as a result of attempting to get up to the washroom and that all recommendations from PT #113 are communicated verbally with unit nurses, ADOC #117, or the DOC for implementation in the plan of care.

In an interview, PT #113 stated that they communicated their recommendations through their written post fall assessments and through verbal communication to ADOC #117 or the DOC. PT #113 stated that they usually only communicated with the unit nurses if there was a significant change in a resident's interventions, otherwise ADOC #117 followed up with the nurses.

In an interview, RPN #116 indicated that resident #001 often tried to use the washroom on their own, even though they were not safe to ambulate on their own. RPN #116 indicated that resident #001 was not on a toileting schedule, and that their plan of care had not been updated to reflect the increased monitoring frequency, and acknowledged a lack of collaboration within the interdisciplinary team.

b. A CIS report was submitted to the MOHLTC related to resident #003 who sustained an injury as a result of a fall on an identified date, which resulted in a transfer to hospital and significant change in their health status.

Review of resident #003's progress notes and assessments stated that at admission a

Fall Risk Screen assessment was completed by RPN #120, identifying them as being at risk for falls.

Further review of resident #003's post fall assessment records showed they had 14 documented falls over a specified three month period.

Review of PT #113's recommendations in the post fall assessments completed for resident #003, included frequent and increased monitoring for safety and fall prevention after seven of the above 14 documented falls. Post fall assessments conducted in the first month of the three month period showed that staff reported that resident #003 was already on a toileting schedule. PT #113 also recommended a scheduled toileting plan for resident #003 in a post fall assessment at the end of the first month of the three month period, and recommended to follow the toileting schedule in three assessments in the third month.

In an interview, RPN #120 indicated that recommendations made by the PT were received verbally by nursing staff who were then responsible for updating the resident's plan of care, and informing the unit staff of the specified changes.

In an interview, PSW #119 indicated that when they began caring for resident #003 they observed a pattern of the resident standing up to use the washroom, resulting in falls. PSW #119 further stated that resident #003 would tell them that they were trying to use the washroom when they fell.

In an interview, PSW #121 indicated that when a toileting schedule was developed and implemented in the plan of care, a task would be assigned in the POC. A review of resident #003's plan of care, POC, and progress notes, since admission over the above specified three month period, did not show that resident #003 was on a scheduled toileting plan, or that monitoring for falls prevention was increased.

In interview, ADOC #117 acknowledged that a toileting schedule was not implemented for resident #003 as recommended by PT #113.

In an interview, RPN #118 indicated that toileting schedules and increased monitoring were fall intervention strategies used in the home for residents at risk for falls. RPN #118 acknowledged that the recommendation to increase monitoring and implement a toileting schedule for resident #003 was not included in the resident's plan of care, and that a toileting plan was not implemented. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A review of resident #003's progress notes and assessments stated that upon admission, a Fall Risk Screen assessment was completed by RPN #120, identifying them as being at risk for falls. The assessment showed that the resident was at risk due to several factors including a history of falls prior to admission.

In an interview, PT #113 indicated that upon admission resident #001 had a history of falls and family members identified risk for falls due to an identified behaviour and history of falls with injury.

In an interview, ADOC #117 stated that interventions should be implemented as soon as possible once a resident is assessed to be at risk for falls, and that specified interventions would be initiated, especially if family members identified that a resident exhibited the above identified behaviour which increased their falls risk.

Review of resident #003's plan of care identified fall prevention interventions were in place, which did not include the above specified interventions mentioned by ADOC #117.

Review of resident #003's post fall assessment records, and progress notes indicated that the resident experienced a fall on an identified date when they exhibited the above identified behaviour. Resident #003 had a subsequent fall incident with injury two days later when exhibiting the same identified behaviour. Review of resident #003's plan of care showed it was updated after the second fall to include one of the above interventions identified by ADOC #117.

In interviews, RPN #118 and RPN #120 stated that the above identified fall interventions could be initiated by any registered staff for residents who were assessed to be at risk for falls. RPN #120 further stated that resident #003 had exhibited the above identified behaviour, and that specified interventions were implemented following the second fall, but was unsure why the plan of care was not reviewed and revised following the first fall. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 5th day of June, 2019

[redacted]

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), BABITHA SHANMUGANANDAPALA (673)
Inspection No. / No de l'inspection :	2019_767643_0016
Log No. / No de registre :	008646-18, 009923-18, 012048-18, 012773-18, 017378-18, 027233-18, 030125-18, 002231-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 30, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Kennedy Lodge 1400 Kennedy Road, SCARBOROUGH, ON, M1P-4V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Grace Campo

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (4).

Specifically, the licensee must:
1) Ensure that for residents #001, #003 and all other residents who are at high risk of falls or experience frequent falls, that strategies and recommendations from the Physiotherapist (PT) and any other interdisciplinary team members are communicated to the direct care staff, are included in the residents' written plan of care and implemented;
2) Develop an on-going auditing process to ensure that strategies and recommendations are communicated to the direct care staff, are included in the residents' written plans of care and are implemented; and
3) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

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related to resident #001 who sustained an injury on an identified date, which resulted in a transfer to hospital and experienced a significant change in their health status.

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The severity of this issue was determined to be a level 3 as there was actual harm to residents #001 and #003. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 2 history as there were 1 or more unrelated non-compliances issued in the last 36 months. (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 30th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

Service Area Office /
Bureau régional de services : Toronto Service Area Office