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

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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
Sep 25, 2019	2019_767643_0026	011304-19, 016878-19	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

ADAM DICKEY (643)

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): September 4, 5 and 6, 2019.

The following complaint intake was inspected during this inspection:
Log #016878-19 - related to withholding admission to the home.

The following Compliance Order follow-up intake was inspected during this inspection:
Log #011304-19 - related to plan of care for falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Associate Directors of Care (ADOC), Social workers (SW), Physiotherapist (PT), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection the inspector conducted observations of staff to resident interactions and the provision of care, reviewed resident health records, reviewed health records for applicants to the home, reviewed auditing records of resident care plan documentation and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2019_767643_0016	643

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident related to their falls prevention and management interventions.

As part of follow-up inspection into Compliance Order CO #001, under inspection report #2019_767643_0016, issued May 30, 2019, with a compliance due date of August 28, 2019, resident #001's plan of care was reviewed. Review of resident #001's current plan of care showed an intervention to ensure a specified safety intervention was in place on an identified date. A second intervention was shown in the care plan indicating the same safety intervention was not to be put in place.

Observation of resident #001's room on an identified date showed the above mentioned safety intervention was in place.

In an interview, PSW #104 indicated that resident #001 was at risk for falls and had interventions in place for falls prevention and management which included the above identified safety intervention. PSW #104 indicated that they would place the safety intervention when resident #001 was in bed, and when they were not in bed the safety intervention would be removed. PSW #104 indicated that the care plan was not clear on when to use the above safety intervention for resident #001.

In an interview, RPN #105 indicated that resident #001 was at risk for falls and had interventions in place which included the above mentioned safety intervention in place when the resident was in bed. RPN #105 indicated that there had been a change in resident #001's condition and was not getting up by themselves as much as in the past. RPN #105 indicated that when resident #001 was more independent the above safety intervention was not in use. RPN #105 indicated that there was conflicting information contained in the written care plan for resident #001 related to the application of the specified safety intervention.

In an interview, the DOC indicated that for resident #001 the care plan did not give clear direction to staff related to the specified safety intervention. The DOC indicated that the two entries were conflicting and was a result of a change in condition for the resident, who was previously more mobile and had the potential to have an accident related to using the safety intervention, then as resident #001 became less mobile the safety intervention was re-instituted to prevent injury from a fall if the resident attempted to get up unassisted. [s. 6. (1) (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 that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to approve an applicant's admission to the home under s. 44. (7) of the Long-Term Care Homes Act (LTCHA),2007.

As outlined in LTCHA, 2007, S.O., c. 8, s. 44. (7), the licensee shall approve the applicant's admission to the home unless the home lacked the physical facilities necessary to meet the applicant's care requirements; the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or circumstances existed which were provided for in the regulations as being a ground for withholding approval.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) by the Central East Local Health Integration Network (CELHIN) challenging the withholding of applicant #010's admission to the Long-Term Care home. As a result of identified noncompliance with LTCHA 2007, c. 8, s. 44. (9) for applicant #010, the sample of applicants reviewed was expanded to include applicants #011 and #012. The written notice withholding resident #011's approval for admission failed to meet the requirements of this provision.

Review of a written notice sent to CELHIN on an identified date showed applicant #011's admission to the home was withheld due to their care needs. The notice indicated that applicant #011's behavioural assessment tool (BAT) showed they had exhibited specified responsive behaviours. The notice indicated that applicant #011 would require a behavioural unit (BSO) and the home did not have a BSO unit. The letter did not specify a lack of nursing expertise, nor lack of physical facilities required to provide for the applicant's care needs.

In an interview, SW #103 indicated that applications for admission were reviewed by SW #107 or themselves and a summary would be prepared of the applicant's care needs and history. SW #103 indicated that the application package would then be given to the nursing department for interdisciplinary review. SW #103 indicated that behaviours of physical aggression, wandering and exit seeking were reasons an applicant might be denied admission due to either a lack of nursing expertise or physical facility. SW #103 indicated that the home did not have BSO funding, however had a responsive behaviour program in place with consulting from a Psychogeriatrician and process for referral to specialized resources if required.

In interviews, DOC #100, ADOC #101 and ADOC #102 indicated that the home had a responsive behaviour program in place to manage behaviours in the home. Staff #100, #101 and #102 indicated that staff in the home were trained with gentle persuasive

approach (GPA) and annual training on residents with dementia related behavioural issues. DOC #100, ADOC #101 and ADOC #102 indicated that the home had a behaviour team in place, conducting weekly rounds and with monthly consultation with Psychogeriatrician and psychogeriatric outreach program (POP) nurse for residents exhibiting responsive behaviours. ADOC #101 indicated that residents whose behaviours were putting others at risk could be referred to Toronto Research Institute or Ontario Shores for observation and further assessment and intervention.

Review of applicant #011's BAT completed prior to applying for admission to the home showed the applicant exhibited a specified behavioural symptom on one occasion and had not been present in the three months prior to assessment. According to the BAT the applicant's family member indicated the applicant had an identified trigger and behavioural response to that trigger with effective interventions listed The BAT further showed applicant #011 had exhibited a second specified behavioural symptom, with effective interventions in place. The BAT showed applicant #011 had exhibited a third specified behavioural symptom related to their health decline. The third specified behavioural symptom was noted to have occurred once in the 12 months prior to assessment but had not occurred again since.

In an interview, ADOC #102 indicated that they did not see any specific requirement in applicant #011's records that showed they would require a BSO unit. ADOC #102 did not cite specific care needs that applicant #011 would require that the home did not have the nursing expertise to manage.

In an interview, DOC #100 indicated that they had not reviewed the application for admission for applicant #011. The DOC did not indicate a specific care need that the home lacked nursing expertise to manage as a reason for withholding the applicant's application for admission to the home. [s. 44. (7)]

2. The licensee has failed to ensure that when withholding approval for admission for resident #012, a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; and an explanation of how the supporting facts justified the decision to withhold approval were set out in the written notice given to the persons described in LTCHA 2007, c. 8, s. 44 (10).

Review of a written notice withholding approval of applicant #012's admission to the home showed that the applicant exhibited specified behavioural symptoms and responded with an identified responsive behaviour. The written notice further indicated

that the home did not have the physical facilities and nursing expertise to meet the applicant's special care needs and ensure other resident's safety. The written notice did not contain a detailed explanation of how these supporting facts related to the home.

In an interview, ADOC #102 indicated that the applicant's admission to the home was withheld as the applicant exhibited specified behavioural symptoms and responded with an identified responsive behaviour in the past. ADOC #102 cited a lack of resources to manage residents with responsive behaviours as a lack of nursing expertise. The ADOC indicated that the home lacked the physical facilities of a BSO team and secure unit as physical facilities lacking.

The written notice failed to provide a detailed explanation of the supporting facts as indicated by ADOC #102 which related to the home, nor how these supporting facts justified the decision to withhold approval for admission.

3. The licensee has failed to ensure that when withholding approval for admission, contact information for the Director was set out in the written notice given to the persons described in LTCHA 2007, c. 8, s. 44 (10).

Review of the written notice withholding approval for applicant #010's admission to the home did not show contact information for the Director as required under LTCHA 2007, c. 8, s. 44. (9).

In an interview, SW #103 indicated that they were not including contact information for the Director in the written notice to applicants when withholding approval to the home. The SW indicated that they knew that the letters were previously forwarded to the Director but had not been aware of the requirement for contact information to be provided in the notice.

As a result of identified noncompliance with LTCHA 2007, c. 8, s. 44. (9) for applicant #010 the sample of applicants reviewed was expanded to include applicants #011 and #012.

Review of the written notices provided when admission was withheld for applicants #011 and #012 did not show contact information for the Director was set out in the notices.

In an interview, the Executive Director indicated they were aware of the requirement to set out the contact information for the Director in the written notices providing when

withholding admission to the home. The ED acknowledged that the home had not included the contact information for the Director in the above written notices. [s. 44. (9)]

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 licensee reviews the assessments and information provided by the placement co-ordinator under LTCHA 2007, c. 8, s. 44. (6) and approves the applicant's admission to the home unless:
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval; and

To ensure that if the licensee withholds approval for admission, the licensee shall give to persons described in s. 44. (10) a written notice setting out:
(a) the ground or grounds on which the licensee is withholding approval;
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
(c) an explanation of how the supporting facts justify the decision to withhold approval; and
(d) contact information for the Director, to be implemented voluntarily.

Issued on this 27th day of September, 2019

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

Original report signed by the inspector.