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
Feb 4, 2020	2020_644507_0004	017460-19	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

STELLA NG (507)

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): January 29, 30 and 31, 2020.

The following intake was inspected during this inspection:
Log #017460-19 related to abuse allegation and plan of care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT) and Substitute Decision-Maker (SDM).

During the course of the inspection, the inspector observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed resident health records and home records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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	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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #011 in accordance with the directions for use specified by the prescriber.

A complaint received by the Ministry of Long-Term Care (MLTC) from resident #011's family member indicated that the resident was denied of an identified treatment which was considered critical to their medical conditions on an identified date.

In a conversation, resident #011's substitute decision-maker (SDM) stated that the resident had identified health conditions and had been using the above mentioned identified treatment continuously for a number of years. After admission to the home, resident #011 did not receive the identified treatment continuously.

Review of the health record of resident #011 indicated that the resident was admitted to the home on an identified date with multiple health conditions, and was discharged 18 days later.

Review of the order recap report of resident #011 indicated a phone order of the above mentioned identified treatment continuously was ordered by the resident's home physician on the day after admission, and the end date was 16 days later. Review of the care plan of resident #011, stated one of the interventions was to refer to treatment administration record (TAR) for current treatments of the identified treatment. Review of the electronic medication administration record (eMAR) and eTAR for the months which the resident was in the home did not include the identified treatment.

Review of the progress notes of resident #011 and interviews with staff #105, #107 and #110, indicated that resident #011 did not receive the identified treatment continuously during their stay in the home.

In an interview, staff #103 stated that when the identified treatment order was entered into the Point Click Care (PCC) the day after admission, the staff did not check off the frequency. As a result, the order of identified treatment did not reflect on the eMAR or eTAR.

In an interview, staff #102 stated that they were not aware of the doctor's order of the identified treatment made the day after admission. Staff #102 acknowledged resident #011 did not receive the identified treatment continuously as ordered by the doctor during their stay in the home. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of February, 2020

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

Original report signed by the inspector.