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
Jun 17, 2021	2021_778563_0010	012432-20, 013851-20, 000507-21, 005333-21	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

MELANIE NORTHEY (563)

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 31, June 1, 2 and 3, 2021

The following Critical Incidents (CI) intakes were completed within this inspection:
CI #2654-000013-20 related to staff to resident neglect
CI #2654-000002-21 related to fall prevention
CI #2654-000004-21 related to an incident that caused an injury to a resident
CI #2654-000011-20 related to improper/incompetent treatment of a resident

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Registered Practical Nurses, Personal Support Workers and residents.

The inspector also made observations of residents and care provided. Relevant policies and procedures, investigation notes, as well as clinical records and plans of care for identified residents were reviewed.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified.

A Critical Incident System (CIS) Report documented resident #005 sustained an injury during care. A complaint submitted to the Ministry of Long-Term Care also reported that a Personal Support Worker (PSW) had provided care causing the resident to sustain an injury.

The resident required a specific level of assistance and staff support for care and did not receive it.

Director of Care (DOC) #102 verified that resident #005 required more assistance than what was provided at the time of the incident and injury.

There was risk of injury when resident #005 was not provided the care that was planned for the resident.

Sources: Risk Management Incident Report, CIS Report, Complaint, resident #005's clinical record, home investigation notes and interviews, and DOC #102’s interview. [s. 6. (7)]

2. The licensee failed to ensure that the outcomes of resident #004’s care was documented.

A Critical Incident System (CIS) Report documented staff to resident #004 neglect. Resident #004 was not provided the care they required and the home's investigation

interviews revealed the PSWs stated they provided the specific care during their shifts. The staff later acknowledged the resident did not receive the specific care as required for seven days when confronted with evidence the care had not been provided.

The Director of Care (DOC) #102 shared that PSWs changed their account of the care provided when the evidence was shown to them. The DOC determined the identified PSW staff falsified documentation related to the specific care provided through the Point of Care (POC) documentation. The DOC showed each PSW that the POC documentation identified care was provided which was not actually provided for resident #004 for seven days.

Inaccurate documentation of resident #004's care outcomes could put the resident at risk for inaccurate care planning and monitoring of potential risk factors. The PSWs did not provide the care required and falsified documentation in POC.

Sources: CIS Report, resident #004's clinical record, home investigation notes and investigation interviews, and DOC #102's interview. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the outcomes of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004 was free from neglect by the Personal Support Worker (PSW) staff in the home.

A Critical Incident System (CIS) Report documented staff to resident #004 neglect. Resident #004 was not provided the care they required and the home's investigation interviews revealed the PSWs stated they provided the specific care during their shifts. The staff later acknowledged the resident did not receive the specific care as required for seven days when confronted with evidence the care had not been provided.

The home's investigation interview with resident #004 was conducted by Social Worker (SW) #121 who spoke resident #004's language. Resident #004 stated they did not receive assistance from staff and the resident attempted to provide care independently. The resident said staff were not assisting them, and they stopped asking. Resident #004 said to SW #121 that they would love to get some help.

The plan of care noted resident #004 required assistance from staff for specific care required.

PSW #109 was interviewed by Inspector #563 and shared they suspected staff were not providing the care required. PSW #109 shared they provided care for resident #004 on multiple dates and admitted to seeing a specific intervention in use for seven days that should have been changed each shift. PSW #109 had six opportunities to report the neglect to their supervisor and did not. PSW #109 perpetuated the neglect by continuing to ignore the care required and potential risk factors.

The Director of Care (DOC) #102 stated PSW #109 neglected the required care for resident #004 for multiple days. The DOC assessed resident #004's care needs by bringing an interpreter during the assessment and it was discovered that resident #004 required staff support for specific care.

The outcome of the home's investigation confirmed neglect.

Sources: CIS Report, resident #004's clinical record, home investigation notes and investigation interviews, PCC Reports, and PSW #109 and DOC #102 interviews. [s. 19. (1)]

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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Revera Mandatory Reporting of Resident Abuse or Neglect policy last reviewed March 31, 2021, stated that a person who had reasonable grounds to suspect that neglect occurred or may occur, must immediately report the suspicion and the information upon which it was based to the person in charge.

PSW #109 was interviewed by Inspector #563 and shared they suspected staff were not providing the required care but did not report their suspicions to management. PSW #109 shared resident #004 was not provided the specific care and did not report the neglect to their supervisor. PSW #109 stated they reported the neglect to Registered Practical Nurse (RPN) #119 on two separate dates, and only shared the same information with other PSWs on one day. No PSWs reported the suspected neglect to their supervisor or management.

The home's investigation revealed the suspected neglect was reported to the RPN by PSW #109. RPN #119 stated they did not report this to management because they were “too busy”.

The home's investigation revealed PSW #109 told PSW #122 that resident #004’s care was neglected. PSW #122 admitted to knowing PSW #109 was watching to see if the resident’s care was provided as required. PSW #122 did not report PSW #109’s suspicions of neglect related to specific care required. Reporting allegations of suspected neglect to the management of the home would have served to protect resident #004. Resident #004 was at risk for continued neglect.

Sources: CIS Report, resident #004's clinical record, home investigation notes and investigation interviews, and PSW #109’s interview. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

Issued on this 18th day of June, 2021

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

Original report signed by the inspector.