



**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 le Loi de 2007 les foyers de soins de longue**

**Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch  
Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité**

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 25, 28, 29, Dec 1, 2, 2011	2011_031194_0036	Critical Incident

**Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.  
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

**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**

CHANTAL LAFRENIERE (194)

**Inspection Summary/Résumé de l'inspection**

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care(ADOC),and an identified resident.

During the course of the inspection, the inspector(s) reviewed the clinical health record for the resident, the licensee's internal investigation reports, the Critical incident report

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 subsections:**

**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).**

**Findings/Faits saillants :**

1. An identified resident's current plan of care indicates that the resident requires two person/total dependence and mechanical lift for transfer.

The Personal Support Workers daily flow sheets indicates that the resident requires 2 staff assist.

A personal support worker did not ensure that the care set out for the resident was provided as specified in the plan of care, when the staff did not obtain two staff assist for transferring resident on a mechanical lift, which resulted in an injury

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The current care plan and the personal support worker daily flow sheets, indicate that an identified resident requires mechanical lift for all transfers with two staff assist.

It was determined during the home's internal investigation of the incident that, the identified resident was transferred by staff, on a mechanical lift without two staff assistance.

As a result of the improper transfer the resident sustained an injury.

**Issued on this 2nd day of December, 2011**



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