Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: May 4, 2023	
Inspection Number: 2023-1160-0003	
Inspection Type: Follow up Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Kennedy Lodge, Scarborough	
Lead Inspector Christine Francis (740880)	**Inspector Digital Signature** Christine Francis Digitally signed by Christine Francis Date: 2023.05.04 15:22:25 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-28, 2023 and May 1, 2023

The following intake(s) were inspected:

- Intake: #00021203 - related to a follow-up to CO #001 from inspection #2023_1160_0002 regarding FLTCA, 2021, s. 6 (7) Plan of Care with CDD of March 31, 2023
- Intake: #00022036/2654-000005-23 - related to a fall resulting in injury
- Intake: #00084595/2654-000006-23 - related to alleged physical/emotional abuse of a resident by a staff member resulting in injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1160-0002 related to FLTCA, 2021, s. 6 (7) inspected by Christine Francis (740880)

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

The licensee has failed to ensure the rights of resident #002 were fully respected and promoted, particularly related to the refusal of consent to any care provided.

Rationale and Summary
On an identified date, resident #002 refused consent for care to be provided by a particular staff member.

The home's internal investigation notes revealed that the staff member was aware of the resident's refusal for care, however, they continued to provide care after the resident declined.

Director of Care (DOC) acknowledged that resident #002 refused consent for care to be provided by the identified staff member, however it was still provided. DOC also acknowledged that the residents' rights were not fully respected and promoted as the resident did not provide consent for the care provided.

There was an impact that resident #002's rights were not fully respected and promoted, and a risk of physical harm.

Sources: The home's internal investigation notes, and interview with DOC.

[740880]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring devices or techniques when assisting resident #001.

Rationale and Summary
On an identified date, resident #001 was observed being transferred with a level of assistance that differed from their care plan.

Personal Support Worker (PSW) #103 acknowledged that resident #001 was not transferred with the correct level of assistance as per their care plan.

There was an increased risk that resident #001 could have fallen and sustained an injury when they were not transferred according to their care plan.

Sources: Observation on an identified date, resident #001's care plan, and interview with PSW #103.

[740880]