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
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Original Public Report

Report Issue Date: October 3, 2023	
Inspection Number: 2023-1160-0004	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Kennedy Lodge, Scarborough	
Lead Inspector Cindy Ma (000711)	**Inspector Digital Signature** Shuang Yu Ma Digitally signed by Shuang Yu Ma Date: 2023.10.05 12:18:01 -04'00'
Additional Inspector(s) Arther Chandramohan (000720) Training Specialist, Christine Francis, was also present during this inspection as an assessing mentor.	

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 25-29, 2023.

The following intake(s) were inspected:
- Intake #00088130, Critical Incident (CI) #2654-000007-23; and Intake #00093857, CI #2654-000010-23 were related to falls

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the

conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the planned care for a resident was set out to include a specified equipment as part of their falls management interventions.

Rationale and Summary

A specified equipment was observed placed beside a resident's bed.

The resident's care plan did not note the use of the specified equipment as part of their falls management interventions.

A Personal Support Worker (PSW), a Registered Practical Nurse (RPN) and a Registered Nurse (RN) confirmed that the use of the equipment was not written in the resident's care plan as part of the fall management interventions.

The RPN, RN and an Associate Director of Care (ADOC) stated that the resident's care plan should have included the use of the specified equipment as part of the resident's fall management interventions.

After being notified, the RPN updated the resident's care plan to include utilizing a specified equipment as part of the resident's fall management interventions.

There was a low risk to the resident when the planned care was not set out in their care plan since the care provided adequately met the resident's current needs.

Sources: Resident's care plans; observations in September 2023; interviews with a PSW and other staff [000711]

Date Remedy Implemented: September 26, 2023

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a logo was placed on a resident's assistive device as specified in the resident's plan of care.

Rationale and Summary

A resident had a history of falls, and was to have a logo placed on their assistive device.

Observations revealed the resident's assistive device did not have the logo posted.

A PSW and an RPN verified the logo was not in place, and confirmed this intervention was listed in the plan of care.

Failure to have the logo on the resident's assistive device placed the resident at an increased risk of harm.

Sources: Observations of resident, review of plan of care, and interviews with staff.
[000720]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

On a day in August 2023, a resident had a fall. Review of the resident's clinical record did not identify a post fall assessment was conducted.

An RN confirmed that a post-fall assessment was not completed.

The RN and an ADOC acknowledged that a post-fall assessment should have been completed after the resident fell.

There was risk that the resident would not receive timely treatment when their post-fall assessment was not completed.

Sources: Resident's clinical records; and interviews with the RN and ADOC.
[000711]