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: November 18, 2024

Inspection Number: 2024-1160-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Kennedy Lodge, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2024 and November 1, 4-7, 2024

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00123902 - 2654-000020-24 - related to a fall of resident resulting in injury
- Intake: #00125400 - 2654-000023-24 - related to improper transfer of resident resulting in injury
- Intake: #00127977 - 2654-000028-24 - related to alleged physical and emotional abuse of a resident
- Intake: #00129029 - 2654-000031-24 - related to injury of unknown cause
- Intake: #00130727 - 2654-000042-24 - related to alleged physical abuse and neglect of a resident

The following CIS intakes were completed during this inspection:

- Intake: #00125822 - 2654-000024-24 - related to a fall of resident resulting in injury
- Intake: #00130717 - 2654-000040-24 - related to a fall of resident resulting in injury

- Intake: #00130021 - 2654-000036-24 - related to improper/incompetent care resulting in injury
- Intake: #00129709 - 2654-000032-24/2654-000033-24 - related to improper transfer of resident
- Intake: #00128125 - 2654-000029-24 - related to injury of unknown cause

The following Complaint intake(s) were inspected:

- Intake: #00126697 - related to alleged neglect and improper care of a resident
- Intake: #00129829 - related to injuries of unknown cause

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's written plan of care had clear directions related to their identified intervention.

Rationale and Summary:
The residents care plan stated that their identified intervention must be applied at all times. While resident was in bed, they were not wearing the identified intervention.

A personal support worker (PSW) confirmed that the resident was not wearing the identified intervention and explained they received instruction two weeks prior from a Registered Nurse (RN) that the intervention must be applied only when the resident is in their wheelchair and removed when the resident is in bed.

The RN acknowledged the residents care plan was not updated and did not provide clear direction.

Failure to ensure that there were clear directions in the residents written plan of care increased the risk of the intervention not being effectively used.

On November 1, 2024, the residents care plan was updated with revision to remove the identified intervention when resident is in bed.

Sources: The resident's care plan, observations, and interviews with the home's staff.

Date Remedy Implemented: November 1, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure the resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary:
A resident sustained a fall that resulted in an injury.

A RN and the Falls Lead acknowledged that the resident had an identified responsive behaviour which increased their risk of falls. The RN and Falls Lead stated the resident was on a specified schedule which the staff were following, however the written care plan was not updated to include the specific schedule.

On November 4th, 2024, the resident's care plan was updated to include the specified schedule.

Sources: The resident's clinical record; interviews with the home's staff.

Date Remedy Implemented: November 4, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights

of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect was fully respected and promoted by a PSW.

Rationale and Summary:
A PSW was witnessed by a Registered Practical Nurse (RPN) placing their hand over a resident's mouth, holding both cheeks.

The RPN and Assistant Director of Care (ADOC) acknowledged that the PSW did not treat the resident with courtesy and respect.

Failure to ensure that the resident was treated with courtesy and respect resulted in an escalation in their behaviour.

Sources: The home's investigation notes; CIS #2654-000028-24; Interviews with the home's staff

WRITTEN NOTIFICATION: Collaboration

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that the staff involved in the care of a resident collaborated with each other in the implementation of the plan of care related to retrieving blood work.

Rationale and Summary:
A resident's substitute decision-maker (SDM) placed a request for blood work to be completed. A note was left in the unit communication book for the nurse to follow up with the physician. No note was left in the physician's communication book.

The resident's progress notes and charts were reviewed and no order for blood work was placed.

The ADOC reviewed the resident's chart and acknowledged that an order was not placed for the blood work.

Sources: Unit communication book, interviews with the home's staff, resident's progress notes and chart

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that the resident's SDM was given the opportunity to participate fully in the development and implementation of their plan of care related to their physiotherapy and medications.

Rationale and Summary:
The resident's plan of care for physiotherapy was altered due to a change in their health status and there was no documentation that their SDM was informed of these changes. The physiotherapist acknowledged that they did not inform the resident's SDM of the changes to their plan of care.

Additionally, the resident's medication was increased on two occasions, and there was no documentation that the SDM was informed or gave consent to the first increase. A RN claimed that consent for the medication increase was inferred when the medication was initially started. However, the ADOC explained that consent cannot be inferred and that when a medication is going to be increased, the home must call the SDM to inform them.

Failure to communicate changes in the resident's plan of care to their SDM resulted in uncertainty on how the resident's care was being implemented and a breakdown of communication.

Sources: The resident's progress notes, interviews with the home's staff.

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary:
The resident's plan of care indicated to leave and re-approach in 5-10 minutes as a behaviour intervention.

The PSW acknowledged that the resident was exhibiting physically aggressive behaviours during care. A RPN confirmed the PSW was requested to leave the resident's room however, the PSW continued providing care, which resulted in an escalation in behaviours.

The ADOC acknowledged that staff failed to follow the resident's written plan of care when the resident had responsive behaviors.

There was a risk of injury to the resident and the PSW when the plan of care was not followed.

Sources: The resident's clinical record; home's investigation notes; and interviews with the home's staff.

WRITTEN NOTIFICATION: Safe Transfer

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale Summary:
A PSW transferred a resident from bed to wheelchair without using a specific transfer device for the transfer.

The resident's care plan stated a specific transfer device was required for transfers.

The PSW and Director of Care (DOC) confirmed that the resident was transferred unsafely, resulting in an injury to the resident.

Failure to ensure safe transferring techniques were used resulted in the resident sustaining an injury.

Sources: The resident's clinical records; home's investigation notes; and interview with the home's staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure a resident's bruise was reassessed weekly for one

period.

Rationale and Summary

A resident developed an altered skin integrity which resolved in four weeks. A review of the skin and wound assessments determined that there was no reassessment conducted on the third week. The Skin and Wound Lead stated that the home would expect staff to reassess a resident's altered skin integrity every week.

Failure to ensure that a resident's altered skin integrity was assessed weekly may result in lost opportunities to implement appropriate interventions.

Sources: Review of the resident's skin and wound assessments; Interviews with the home's staff.