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: February 8, 2023	
Inspection Number: 2023-1160-0002	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Kennedy Lodge, Scarborough	
Lead Inspector Wing-Yee Sun (708239)	**Inspector Digital Signature** Wing Yee Sun 2023.02.23 12:38:32 -05'00'
Additional Inspector(s) Dorothy Afriyie (000709) was also present during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 25-27, 30-31, 2023

The following intake was inspected in this Critical Incident System (CIS) inspection:
- Intake: #00017381, CIS #2654-000001-23 was related to falls prevention and management.

The following intakes were completed in the CIS inspection:
- Intake: #00001370, CIS #2654-000010-22,
- Intake: #00002802, CIS #2654-000001-22,
- Intake: #00004081, CIS #2654-000007-21,
- Intake: #00006033, CIS #2654-000009-21,
- Intake: #00006521, CIS #2654-000017-22 and
- Intake: #00009131, CIS #2654-000019-22 were related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any action taken with respect to the resident under the falls prevention and management program, including the interventions and the resident's responses to interventions were documented.

Rationale and Summary

The resident had a history of falls with injuries prior to admission to the home. The resident fell multiple times after their admission. The family provided a fall prevention intervention to be used with the resident to minimize injury.

The Physiotherapist (PT) acknowledged that the fall prevention intervention was implemented with the resident the same day it was brought in. This fall prevention intervention was entered on the care plan the following day. Between specified dates, the resident's progress notes did not mention the use or the resident's response to the use of the fall prevention intervention.

A Registered Practical Nurse (RPN) failed to document the fall prevention intervention in Point of Care (POC) for frontline staff to check that it was in place. A Registered Nurse (RN) and another RPN both acknowledged that the resident had the tendency to take off the fall prevention intervention and did not document the resident's response to the intervention.

The Director of Care (DOC) acknowledged that staff were expected to document the intervention in POC and the resident's response to using the fall prevention intervention and did not.

Failure to ensure the interventions and the resident's response to interventions were documented put the resident at risk of not having interventions reassessed for their effectiveness.

Sources: Critical Incident (CI) report, the resident's progress notes and care plan, interviews with a RN, RPN and other staff.

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WRITTEN NOTIFICATION: Compliance with Manufacturers' Instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 26

The licensee has failed to ensure staff used all devices in the home in accordance with manufacturer's instructions.

Rationale and Summary

The resident required a specific device.

A Personal Support Worker (PSW) acknowledged that when the resident fell, they felt their device was not working. They signed off on the POC documentation for the device, however they acknowledged they did not check if the device was working during their shift.

Based on the manufacturer's instructions for the device, it was recommended that they are tested daily and before each use.

The RN reported they were not informed that the resident's device was not working when the resident fell. The Associate Director of Care (ADOC)/Falls Lead and the DOC acknowledged that the PSW was responsible to ensure the device worked.

Failure to ensure the resident's device was used in accordance with manufacturer's instructions increased the resident's risk of falls**.**

Sources: The resident's care plan, manufacturer's instructions for the device, interviews with a PSW and other staff.

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COMPLIANCE ORDER CO #001 Plan of Care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

(a) Conduct random audits of compliance with use of fall prevention interventions for a period of three weeks following the service of this order.
(b) Maintain a record of the audits, including the date, who conducted the audit, name of the staff being audited, results of each audit and actions taken in response to the audit findings.

Grounds

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

Rationale and Summary

(i) A CI report was submitted for a fall. The resident was found on the floor with a change in level of consciousness and an injury. The resident was transferred to the hospital, sustained injuries, and died in the hospital.

The resident was assessed related to their mobility and placed on a program. Based on their post fall assessment it indicated they required close monitoring. The staff acknowledged that the resident was kept in a specified location for monitoring due to their falls risk.

The RN kept the resident in a specified location to provide close monitoring. They had informed the PSW that the resident was at risk of falls and required close monitoring. The PSW brought the resident from the specified location to the resident's room and was going to transfer the resident to bed. The PSW did not transfer the resident to bed immediately and went on to complete documentation, leaving the resident alone in the room in their mobility device. The resident had an unwitnessed fall in their room after they were left unattended.

During the investigation, the home identified through camera footage that the PSW should have stayed with the resident but failed to provide close monitoring when they left the resident unattended in their room prior to the fall. The DOC acknowledged that the PSW should have stayed with the resident in their room if they did not transfer the resident to bed immediately.

Failure to provide close monitoring set out in the plan of care for the resident resulted in a fall with injury.

Sources: CI report, home's investigation notes, resident's clinical file, interviews with a RN, PSW, DOC and other staff.

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Rationale and Summary

(ii) The resident was screened to be at risk for falls and falls with injury due to their mobility and cognitive status, and previous falls with injury.

Upon admission, the resident had multiple fall prevention interventions initiated and another specific intervention initiated after sustaining falls in the home.

A RPN acknowledged that when they worked on a specified date, one of the fall prevention interventions that was initiated upon admission, a portion of the intervention was missing. Another RPN acknowledged that on subsequent days, they did not see this intervention in place. After a fall, it was noted that the resident did not have the specific intervention in place. When the resident fell again and sustained an injury and was transferred to the hospital, a PSW acknowledged that the resident did not have the intervention in place. The ADOC/Falls Lead acknowledged that only one of the specific fall prevention intervention was provided when it was initiated and no replacement was available for the resident.

Another specific fall prevention intervention was initiated for the resident after they sustained falls in the home. After the intervention was initiated, the first RPN acknowledged that they did not apply the intervention with the resident when they worked. A RN and PSW acknowledged that the resident was not using the fall prevention intervention at the time of their next fall.

The PT, ADOC/Falls Lead and DOC acknowledged that the resident should have used both interventions at all times. The DOC acknowledged that the resident was not using both fall prevention interventions when they fell.

Failure to provide the resident with both fall prevention interventions set out in the plan of care increased risk of sustaining injury post fall.

Sources: The resident's progress notes and care plan, interviews with a RPN and other staff.

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This order must be complied with by March 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.