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

Public Report

Report Issue Date: January 31, 2025
Inspection Number: 2025-1160-0001
Inspection Type: 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): January 22, 27-31, 2025
The inspection occurred offsite on the following date(s): January 23-24, 2025
The following intake(s) were inspected:

- Intake: #00130800 - Related to sudden or unexpected death of a resident
- Intake: #00132548 - Related to disease outbreak
- Intake: #00133091 - Related to improper transferring/positioning
- Intake: #00134110 - Related to disease outbreak

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure the there was adequate collaboration between staff with respect to a resident's diet. Dietary referrals/follow-up were not followed and the resident was served a diet that did not match the type ordered. A number of staff in the home were unaware that the diet being served did not match the one in the resident's dietary plan.

Sources: Review of clinical records, review of the resident's care plan, Critical Incident System reports, the Home's Internal Investigation Records, and interviews with various staff members. [741150]

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
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 leg straps on a sit-stand mechanical lift were found to have not been secured

while staff assisted a resident with transferring in 2024. Home staff acknowledged that the transfer technique was unsafe and posed a risk of injury to the resident.

Sources: Critical Incident System report, the homes internal investigation records, Safe Ambulation Lift Transfer Skills Checklist and interviews with home staff. [741150]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The Licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). Specifically, the Licensee failed to ensure that, at a minimum, quarterly audits were conducted during the months preceding the inspection to ensure that all staff can perform the IPAC skills required for their role in accordance with Section 7.3 (b) of the Infection Prevention and Control (IPAC) Standard.

Sources: Review of the home's IPAC documentation, IPAC Standard for Long-Term Care Homes (LTCH), and an interview with home staff. [000851]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that there are policies and procedures in place to determine the frequency of cleaning and disinfection using a risk stratification approach in accordance with Section 5.6 of the IPAC Standard for Long-Term Care Homes (September 2023). Specifically, the cleaning procedure of the home's third-party housekeeping contractor did not incorporate a risk-based approach to surface cleaning frequencies.

Sources: Reviews of the cleaning procedure and the home's cleaning frequency risk matrix, interview with home staff, the IPAC Standard revised September 2023. [000851]

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