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

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Public Report

Report Issue Date: May 1, 2025

Inspection Number: 2025-1160-0003

Inspection Type:
Proactive Compliance Inspection

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): April 15-17, 22, 24-25, 28-30, 2025 and May 1, 2025.

The following intake(s) were inspected:

- Intake: #00144805 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain 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 (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 that a resident's plan of care was reviewed and revised, when the resident's care needs changed. The resident required a particular level of assistance with an activity of daily living (ADL) as per their plan of care. However, during an observation, the resident was provided a different level of assistance for the ADL and the staff confirmed the required level of assistance.

Following the inspector's observation, the plan of care was revised to reflect the resident's current care needs.

Sources: Resident's clinical records and interviews with staff.

Date Remedy Implemented: April 28, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with the IPAC Standard for Long-Term Care Homes, revised September 2023, section 11.6, the licensee has not ensured that signage was posted throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

At a later date, it was observed that the signage had been posted throughout the home.

Sources: Observations in the home; and interview with the IPAC Manager.

Date Remedy Implemented: April 25, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that the Residents' Council and Family Council received a copy of the home's annual Continuous Quality Improvement (CQI)

initiative report. The Executive Director (ED) and the Program Manager, later confirmed that they have distributed a copy of the report to both the councils at a subsequent date.

Sources: Residents' and Family Council Meeting Minutes; interviews with the President of the Residents' Council, President of the Family Council, Program Manager and the ED.

Date Remedy Implemented: May 1, 2025

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when unsupervised. During an observation, the door to the electrical room on the ground floor which residents did not have unsupervised access to, was observed to be open and unlocked.

Sources: Observation and interview with the Environmental Service Manager (ESM).

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (2)
Doors in a home
s. 12 (2) The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. Specifically, the home's policy on door safety did not contain information to indicate the door to the home's patio on the main floor must be locked or unlocked to permit or restrict unsupervised accessed by residents.

Sources: Observation, Home's Door Safety policy (CARE10-O10.07, last reviewed date March 31, 2023), and interview with the ESM.

WRITTEN NOTIFICATION: Menu planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (b)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home; and

The licensee has failed to ensure that the Fall/Winter menu cycle was evaluated and approved by the Registered Dietitian (RD) and Nutrition Manager (NM) prior to being in effect. A review of documentation revealed that the evaluation and approval of the menu by the RD and the Nutrition Manager occurred after the menu had already come into effect.

Sources: Home's Fall/Winter menu cycle evaluation, Resident Food Committee meeting minutes and interview with RD.

WRITTEN NOTIFICATION: Medication management system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that staff documented administration of an as needed (PRN) medication to a resident as per the home's policy.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols are developed for the medication management system and must be complied with.

Specifically, staff did not document PRN administration of a controlled drug in the electronic medication administration record (eMAR). The Director of Care (DOC) stated that the staff should sign off the PRN medication in the eMAR, and they did not meet the home's expectations for medication administration.

Sources: Resident's clinical records; home's "Medication Administration Policy CARE13-O10.01" (last reviewed date March 31, 2024); and interview with DOC.

WRITTEN NOTIFICATION: Orientation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that the training for staff in IPAC required under paragraph 9 of subsection 82 (2) of the Act included (h) handling and disposing of biological and clinical waste including used personal protective equipment. The IPAC Manager was unable to demonstrate that this topic was included in their annual IPAC training for the staff.

Sources: Home's Annual Mandatory Handbook January 2025, Home Specific New Hire Orientation - Day Two; interview with the IPAC Manager.