Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 24, 2019	2019_654618_0024	011014-18, 018012-18, 021618-18, 031457-18, 031628-18, 005140-19, 008254-19, 009048-19, 011062-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

Long-Term Care Home/Foyer de soins de longue durée

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CECILIA FULTON (618), ALICIA MARLATT (590), DEBRA CHURCHER (670), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 21, 2019.

The following intake logs/ Critical Incident System (CIS) reports were inspected:
Log #031628-18, CIS #M545-000058-18 related to personal support services.
Log #011014-18, CIS #M545-000017, 18 and log #021618-18, CIS #M545-000042-18, related to personal support services and hospitalization.
Log # 008254-19, CIS # M545_000021-19, related to falls.
Log # 005140-19, CIS # M545_000012-19, related to falls and late reporting.
Log #018012-18, CIS #M545-00030-18 and Log #009048-19, CIS # M545-000023-19, related to prevention of abuse.
Log #011062-19 CIS #M545-000025-19, related to prevention of abuse and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Managers (NM), Operational Nurse Manager (ONM), Registered Staff (RN/RPN), Physiotherapist, Rehabilitation assistant, and Personal Support workers (PSW).

During the course of the inspection, the inspectors observed residents and resident home areas, and conducted reviews of resident records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Critical Incident System (CIS) report #M545-000025-19 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in 2019.

The residents were discovered by staff to be in a situation which was acknowledged to be abusive and that had been instigated by resident #008 towards resident #009. The identified situation caused distress and embarrassment to resident #009.

Upon discovery of the identified situation, the residents were separated, and both were provided interventions to promote their safety.

ONM #116 identified that they had responded to the incident, and their observations included that the incident left resident #009 quite emotional. ONM #116 identified that they felt resident #008 was aware of the actions they had taken towards resident #009. They identified that there was an awareness by staff of resident #009's interest in resident #008 prior to this incident, and there were some interventions in place.

The licensee had failed to ensure that resident #009 was protected from abuse by resident #008. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The home submitted a CIS report to the MOHLTC in 2019. The CIS report, and the resident's health records identified that resident #006 sustained an injury for which the resident was taken to a hospital and which resulted in a significant change in the resident's health condition on an identified date in 2019.

The licensee has failed to ensure that the Director was informed no later than one business day after resident #006 had an incident that caused an injury which resulted in the resident being taken to the hospital and resulted in a significant change in the resident's health condition. [s. 107. (3) 4.]

Issued on this 24th day of June, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.