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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Amended Public Report
Cover Sheet (A1)

Amended Report Issue Date: September 26, 2024
Original Report Issue Date: September 5, 2024
Inspection Number: 2024-1562-0003 (A1)
Inspection Type: Critical Incident Follow up
Licensee: City of Toronto
Long Term Care Home and City: Kipling Acres, Etobicoke

AMENDED INSPECTION SUMMARY

This report has been amended to:
NC #003 was amended to correct the legislation cited in the definition of abuse
NC #005 was amended to remove the incorrect word "control," related to the infection risk to residents and staff

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Lead Inspector	**Additional Inspector(s)**
Matthew Chiu (565)	
Amended By Henry Chong (740836)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29-31, August 1, 6-9, and 12-13, 2024.

The following Critical Incident System (CIS) intake(s) were inspected:
• #00114860 related to an incident that caused a significant change in resident's health condition;
• #00117241 related to infectious disease outbreaks;
• #00120136 related to falls prevention and management; and
• #00120480 related to prevention of abuse of resident.

The following Follow-up intake(s) were inspected:
• #00116180 related to follow-up of compliance order (CO) #001 from inspection #2024-1562-0002.

The following intake(s) were completed:
• #00115030 related to infectious disease outbreaks; and
• #00115657; #00116634; #00117562 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1562-0002 related to FLTCA, 2021, s. 6 (7) inspected by Matthew Chiu (565)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Responsive Behaviours
Falls Prevention and Management

AMENDED 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 (1) (a)
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,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care set out the planned care for the resident.

Rationale and Summary:
A resident had a written plan of care. Record reviews and staff interviews indicated that a specified care was provided to the resident for their behaviours. However, a review of the resident's written plan of care revealed that it did not set out the specified care. An interview with the Nurse Manager (NM) confirmed that this should have been documented in the resident's written plan of care but was not.

The failure to include the resident's specified care in their written plan of care posed a risk to ineffectively managing the resident's behaviours.

Sources: Resident's progress notes and care plan; interviews with the Personal

Support Worker (PSW) and NM.

WRITTEN NOTIFICATION: Plan of care

NC #002 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 a care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
A resident was at risk for falls, and their falls prevention plan of care included an application of a device.

A record review and staff interviews revealed that during a shift, the resident was found lying on the floor. The NM confirmed that the home's investigation showed the device was in good working condition. If the device had been activated during the incident, it should have produced a signal to alert staff, but it did not. The NM acknowledged that the device was not properly applied to the resident as specified in their plan of care during the incident.

The failure to apply the device posed a risk of ineffectively preventing the resident's fall.

Sources: Resident's progress notes and care plan; home's investigation records; interviews with the PSW, RPN, and NM.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect a resident from physical abuse by another resident.

For the purposes of the definition of "abuse" in subsection (2) of the Regulation, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
Two residents, both with cognitive and physical impairments, were involved in an incident where one of them had a history of physical aggression towards others. Record reviews and staff interviews indicated that during a shift, a PSW observed the aggressive resident using physical force against the other resident. The abused resident was subsequently transferred to the hospital and diagnosed with a medical condition. The NM stated that the incident substantiated that physical abuse towards the abused resident had occurred.

Failure to protect the resident from physical abuse by another resulted in harm to their health.

Sources: Resident's progress notes, home's investigation records; interviews with

the PSW and NM.

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 has failed to ensure that the infection prevention and control (IPAC) standard for long-term care homes, revised September 2023, was implemented in accordance with the standard. Specifically:
- Additional Precautions section 9.1 (f) Additional personal protective equipment (PPE) requirements including appropriate selection application, removal and disposal.

Rationale and Summary:
The home was declared to have a respiratory outbreak in one of its home areas.

During a dining observation, two residents were in isolation in their rooms. A PSW, wearing identified PPE, entered both rooms, delivered food trays, and provided care to the residents.

In an interview, the PSW confirmed these observations. The IPAC Manager stated that the two residents were under additional precautions, and staff should have used appropriate PPE when providing care. The IPAC Manager acknowledged that

the PSW did not use the appropriate selection of PPE as required.

The PSW's failure to use the appropriate PPE when caring for residents under additional precautions increased the risk of infection transmission.

Sources: Observations; interviews with the PSW and IPAC Manager.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a staff member participated in the implementation of the home's IPAC program.

Rationale and Summary:
A respiratory outbreak was declared in one of the home's areas, and the home's IPAC program implemented Public Health's recommendations for managing the outbreak. These included the requirement for staff to wear appropriate PPE while in the affected area.

During a dining observation in the affected area, a PSW was observed providing

care to residents without the appropriate PPE. Later in the shift, the same staff member was again observed not wearing the required PPE in the area. Interviews with the PSW and IPAC Manager confirmed that the home's IPAC practice required all staff to use the appropriate PPE in the outbreak area. The IPAC Manager acknowledged that the staff member did not participate in the implementation of the IPAC practice for using the appropriate PPE in the outbreak area.

The PSW's failure to adhere to the implementation of the IPAC practice during a respiratory outbreak posed an infection risk to residents and staff.

Sources: Home's outbreak management records; observations; interviews with the PSW and IPAC Manager.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of disease of public health significance.

Rationale and Summary:

Review of the CIS and infoline reports, along with staff interview, revealed that a respiratory outbreak was declared by the public health unit. However, record review and an interview with the IPAC Manager confirmed that it was not reported to the Director until the night of the following day.

The failure to report the disease outbreak immediately posed a low risk of delaying interventions needed to monitor and control the spread of the disease.

Sources: CIS and infoline reports; interview with the IPAC Manager.