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: October 29, 2025
Inspection Number: 2025-1562-0008
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Kipling Acres, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22 - 24, 27 - 29, 2025

The following intake(s) were inspected:
Intake: #00156711 Critical Incident (CI) #M545-000063-25 related to a fall a resident resulting in injury.
Intake: #00157202 CI #M545-000068-25 related to a fall a resident resulting in injury.
Intake: #00158184 CI #M545-000072-25 related to a fall a resident resulting in injury.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 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 licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident following a fall incident.

i) A Registered Nurse (RN) and a Personal Support Worker (PSW) both manually lifted a resident off the floor following a fall incident. The Nurse Manager acknowledged the RN and the PSW performed an unsafe transfer and should have used a mechanical lift to transfer the resident as per the home's procedures.

Sources: A resident's clinical records, the home's Falls Prevention and Management Policy, interviews with a RN and the Nurse Manager.

ii) After a resident's fall, staff used a unsafe transportation device to transport the resident around the unit. The Nurse Manager and the Physiotherapy (PT) acknowledged the resident should have been transported with a portable wheelchair.

Sources: A resident's clinical records, interviews with a RN, the PT and the Nurse Manager.

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that an interdisciplinary falls prevention and management program was implemented in the home to reduce the incidence of falls and the risk for injury.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's fall prevention and management policy indicated to notify the physician or Nurse Practitioner immediately if a significant change in resident health status was noted after a fall.

However, when a resident fell and experienced changes to their mobility, the physician was not informed. The Nurse Manager acknowledged the physician should have been notified once the nurses assessed the resident's ambulatory status changed.

Sources: A resident's clinical records, the home's Falls Prevention and Management Policy, interviews with a PSW, a RPN, a RN and the Nurse Manager.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (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 (5):
4. Subject to subsection (4), 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 licensee has failed to ensure that an incident that caused an injury to a resident, for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, was reported to the Director within one business day after the occurrence of the incident.

i) When a resident sustained a fall that resulted in a negative health outcome and resulted in a significant change in their health status, the incident was not reported to the Director within one business day.

Sources: Interview with the Nurse Manager.

ii) When another resident sustained a fall that resulted in a significant change in their health status, the incident was not reported to the Director within one business day.

Sources: Interview with the Nurse Manager.