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 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 2017	2016_382596_0019	028417-16	Complaint

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 9, 12, 13, 14, 15, 16, 2016 and January 10, 2017.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), nurse managers (NM), registered dietitian (RD), registered nurses (RN), registered practical nurses (RPN), physiotherapist (PT), attending physician, practical care aides (PCA), dietary aide (DA), and family member.

The following Inspection Protocols were used during this inspection:

Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of

care was documented.

Record review of a complaint called into the Ministry of Health and Long Term Care (MOHLTC) infoline in 2016, reported that an identified resident was not bathed twice, as per the bathing schedule.

Record review of the identified resident's written plan of care indicated that the resident's showers were scheduled for two specified days of the week on the day shift. Record review of the identified resident's Nursing and Personal Care Record (NPCR) for September 2016 revealed staff sign offs for all scheduled bathing dates except for two specified dates in September 2016.

Interview with an identified practical care aide (PCA) revealed that he/she assisted the resident with bathing on the first specified date in September 2016, day shift but forgot to document on the resident's NPCR.
Interview with another identified PCA revealed that the identified resident refused to bathe on the second specified date in September 2016, day shift, and he/she gave the resident a bed bath, but forgot to document on the NPCR.

Interview with the Director of Nursing (DON) confirmed that staff are expected to document when bathing is completed for all residents.

2. Interview with the complainant revealed that the identified resident had poor intake and experienced a significant change in weight over a four month period.

Record review of the identified resident's medication reconciliation, dated and signed off by the physician in December 2016, indicated an order for a particular supplement three times daily (TID) at snack. Review of the resident 's NPCR food and fluid intake sheet for a specified date in December 2016, did not include a staff sign off for the resident's supplement at bedtime snack.

Interview with an identified PCA revealed that he/she worked on the evening shift on a specified date in December 2016, and was assigned to the identified resident. He/she reported that he/she and the other PCA who worked the short shift were responsible for documenting the resident's snack intake on the resident's NPCR for food and fluid intake, and not sure why it wasn't completed. The identified PCA stated that he/she remembers that the resident received two tablespoons of the supplement at bedtime snack on the specified date in December 2016.

Interview with an identified registered nurse (RN) and the DON reported that PCAs were responsible for documenting food and fluid intake on the NPCR for their assigned residents.

3. Record review of the identified resident's NPCR for food and fluid intake did not include a staff sign off on a specified date in September 2016, for bedtime snack and fluid.
Interview with an identified PCA reported that the resident received the bedtime snack and fluid, on a specified date in September 2016, and he/she missed signing off on the resident's NPCR.

DON confirmed that PCAs were responsible for documenting food and fluid intake on the NPCR for their assigned residents.

4. Record review of the identified resident's NPCR for food and fluid intake did not include staff sign off on a specified date in December 2016, for two meals.

Interview with an identified registered practical nurse (RPN) revealed that he/she worked the a specified date in December 2016, and was responsible for documenting the identified resident's food and fluid intake for the two meal times. The RPN stated that the resident ate 50% of porridge and fluids for breakfast, and ate all the soup for lunch, and a few spoons of the main course. He/she further stated that he/she was not able to complete the resident's NPCR for food and fluid intake on the above mentioned date, as he/she was busy completing other duties. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

Record review of a complaint called into the MOHLTC infoline reported poor care given to an identified resident.
Interview with the complainant revealed that the identified resident's health had been declining, and he/she was transferred to hospital by the home recently. The resident was diagnosed in hospital with two specified diagnoses, treated then transferred back to the home.

Record review of the identified resident's progress notes revealed that on a specified date in November 2016, on the day shift the complainant informed the resident's attending physician that the resident felt warm. The physician assessed the resident and documented that he/she had an elevated temperature, ordered a particular medication, fluids and a diagnostic test.

A review of the identified resident's progress notes did not include documentation of the resident's symptoms of infection during the evening shift of a specified date in November 2016. The following day, on the evening shift the resident's temperature was still elevated with another symptom present, and again elevated on the morning of November 25, 2016; the resident was later transferred to hospital.

Interview with an identified registered practical nurse (RPN) revealed that he/she worked the evening shift on the specified date in November 2016, mentioned above, assessed the resident's symptoms of infection, took the resident's temperature and forgot to document it in the resident's progress notes. The identified RPN could not remember what the resident's temperature was when she took it, but doesn't think it was elevated.

Interview with an identified Nurse Manager (NM) revealed that the home's expectation is that registered staff record resident's symptoms of infection in the progress notes at least once every shift. [s. 229. (5) (b)]

Issued on this 14th day of February, 2017

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

Original report signed by the inspector.