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
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Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2017	2016_370649_0032	030109-16	Critical Incident System

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

JULIEANN HING (649)

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): December 19, 20, and 21, 2016.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator (AA), Director of Nursing (DON), acting nurse manager (A-NM), registered nurses (RN), behavioural support nurse, registered practical nurses (RPN), practical care aides (PCA), food service worker (FSW), and residents.

During the course of the inspection, the inspector observed resident care, observed staff to resident interactions, reviewed health records, reviewed the home's staff training records, staff schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **1 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. 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 has failed to ensure that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

In October 2016, a critical incident report (CI) was submitted to the Ministry of health and Long-Term Care (MOHLTC) stating that resident #001 pushed resident #002 who fell and sustained an injury.

Interview with resident #001 revealed that he/she does not recall the incident that occurred on an identified date in October 2016, and does not remember pushing another resident.

A review of resident #002's most recent minimum data set (MDS) assessment indicated that resident #002 has been diagnosed with cognitive impairment.

Interview with practical care aide (PCA) #100 revealed on the day of the incident he/she heard resident #001 saying to someone get out of here and don't come here and then heard what he/she thought was fighting. PCA reported as he/she was walking towards resident #001 he/she saw resident #002 falling to the ground.

Interview with food service worker (FSW) #101 revealed that he/she had seen resident #001 push resident #002 and he/she fell onto their side. The FSW was unable to say if resident #002 had touched resident #001 from his/her observation point.

Interview with the Director of Nursing (DON) and acting nurse manager (A-NM) #109 revealed that the incident on an identified date in October 2016, was the result of a startled response by resident #001 when resident #002 had walked into his/her space and resident #001 had accidentally pushed the other resident. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

In October 2016, a CI was submitted to the MOHLTC that resident #001 pushed resident #002 who fell and sustained an injury.

Interviews with PCA #110 and #111 and RPN #112 revealed that resident #001 has been seated daily in an identified area within the home since the incident in October 2016, and this intervention should have been captured in resident's written plan of care.

A-NM #109 and DON revealed that resident #001's written plan of care did not include this intervention. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

In October 2016, a CI was submitted to the MOHLTC stating that resident #002 who was pushed by resident #001 sustained an injury.

A review of resident #002's most current written plan of care directed staff to ensure resident is wearing identified protectors.

Observation in December 2016, revealed that resident #002 was not wearing the identified protectors.

Interviews with PCAs #105 and #107, RPN #106 and RN #108 revealed that resident #002 was not wearing any identified protectors on an identified date in December 2016. PCAs #105 and #107 stated that resident had not been wearing the identified protectors since their return from the hospital.

Interview with RN #108 revealed that resident #002's care plan should have been updated to reflect that the resident no longer wandered.

Interviews with A-NM #109, and DON revealed that resident #002's care plan had not been revised and updated when the resident's care needs had changed. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

In October 2016, a CI was submitted to the MOHLTC stating that resident #002 who was pushed by resident #001 had sustained an injury.

A review of the home's policy titled Altercations and Potentially Harmful interactions between and among residents, policy #RC-0306-00, published 01-04-2016, indicated under point #14 of the policy to notify the police; obtain and record the name of the police officer and badge number; a police report is filed (at a minimum) for all allegations of assault.

Interviews with RNs #108 and #104 revealed that the home's policy had not been followed.

Interviews with the DON and A-NM #109 revealed that the home's policy had not been followed. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

In October 2016, a CI was submitted to the MOHLTC stating that resident #001 was pushed resident #002 who then fell and sustained an injury.

Interviews with FSW #101, RN #102, and RPN #117 revealed that resident #001 likes to be alone.

Interviews with RN #115, PCAs #114 and #116 revealed that resident #001 likes to be alone and is seated in an identified area within the home to decrease residents wandering into the resident's path or space.

Interview with the behavioral support nurse #113 revealed that a dementia observation system (DOS) monitoring should have been started after the incident but was unable to provide any record of this documentation.

A review of resident #001's most current written care plan did not indicate that resident #001 likes to be alone and and would display responsive behaviours if other residents wandered into his/her path.

Interview with the DON and A-NM #109 revealed that going forward an assessment needs to be done for resident #001 since there was no assessment completed at the time of the incident. [s. 26. (3) 5.]

Issued on this 27th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649)
Inspection No. / No de l'inspection :	2016_370649_0032
Log No. / Registre no:	030109-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 23, 2017
Licensee / Titulaire de permis :	City of Toronto 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	KIPLING ACRES 2233 KIPLING AVENUE, ETOBICOKE, ON, M9W-4L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nelson Ribeiro

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

1. The licensee shall identify behavioural triggers for resident #001, and develop and implement applicable strategies to protect other residents from abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #002 was protected from abuse by the staff in the home.

The licensee has failed to ensure that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

In October 2016, a critical incident report (CI) was submitted to the Ministry of health and Long-Term Care (MOHLTC) stating that resident #001 pushed resident #002 who fell and sustained an injury.

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Interview with the Director of Nursing (DON) and acting nurse manager (A-NM) #109 revealed that the incident on an identified date in October 2016, was the result of a startled response by resident #001 when resident #002 had walked into his/her space and resident #001 had accidentally pushed the other resident. [s. 19. (1)]

The severity of the non-compliance and the severity of the harm and the risk of further harm is actual harm related to resident's # 002's injury. The scope of the non-compliance is isolated to resident #001. A review of the compliance history revealed that there was a voluntary plan of correction (VPC) issued during inspection #2016_382596_0018, dated January 31, 2017, related to the Long-Term Care Homes Act, 2007, s. 19. (1). (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JulieAnn Hing

Service Area Office /
Bureau régional de services : Toronto Service Area Office