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


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 10, 2018 | 2017_659189_0024 | 024181-17 | 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

NICOLE RANGER (189), CECILIA FULTON (618)

## 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): November 27, 28, 2017.**

**This complaint inspection is in relation to personal support services, continence care, prevention of abuse and neglect, and responsive behaviours.**

**The following Critical Incident System (CIS) was also inspected concurrently during this inspection: CIS related to injury of a resident.**

**During the course of the inspection, the inspector(s) spoke with Assistant Administrator, Nurse Manager, Occupational Therapist (OT), registered nurse (RN), registered practical nurse (RPN), housekeeping aide, personal care assistants (PCA), family member.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 resident #001 was not neglected by the licensee or staff.

Under O. Reg. 79/10, s. 5 for the purpose of the definition of "neglect" in the Act and Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more resident.

On an identified date, the home submitted a Critical Incident System (CIS) to the Ministry of Health and Long Term Care (MOHLTC) reporting an incident that caused an injury to resident #001, which the resident was taken to hospital and resulted in a significant change in the resident's health status.

On an identified date, the MOHLTC received complaint intake #024181-17, related to care received at the home for resident #001. The complainant reported concern related to the incident that occurred on the above identified date, and had concerns regarding if the safety equipment for the resident was in place on the day of the injury.

Review of the written plan of care for resident #001 revealed that the resident is high risk for falls and required the use of safety interventions.

Interview with Personal Care Assistant (PCA) #103 revealed that he/she was assigned to provide care to resident #001 on the identified date. The PCA reported that he/she assisted the resident with personal care and dressing, placed the safety equipment on the resident and took the resident to the dining room. PCA #103 reported that when he/she placed the safety equipment on the resident, he/she noticed that a part of the safety equipment were missing. He/She searched the room and could not find it, but he/she proceeded to place the safety equipment on the resident. PCA #103 reported that he/she forgot to mention to the registered staff that morning that a part of the safety equipment were missing. PSW #103 reported to the inspector that he/she is aware that resident #001 is high risk for falls and required the use of the safety equipment for safety.

Interview with RPN #101 revealed that he/she was the registered staff assigned to the identified unit the morning of the incident. RPN #101 stated that he/she is aware that resident #001 required the use of safety equipment as the resident is high risk for falls. RPN #101 revealed that on the morning of the incident, he/she observed the resident with his/her safety equipment in place while the resident was in the dining room for their meal. RPN #101 reported that at an identified time, he/she was informed by PCA #103 that resident #001 was on the floor, and when he/she assessed the resident,the resident

sustained an injury. Although RPN #101 reported that he/she observed the safety equipment in working order on the day of the incident, it was confirmed by PCA #103 and Nurse Manager #102 that a part of the safety equipment was missing.

Interview with PCA #100, #103, RPN #101, OT #108 and Nurse Manager #102 revealed that resident #001 required the use of the safety equipment as they are high risk for falls. Interview with Nurse Manager #102 confirmed that part of the safety equipment was not in place on the day of the incident, when the resident subsequently sustained an injury.

Interview with Nurse Manager #102 confirmed that PCA #103 did not inform RPN #101 that part of the safety equipment were missing on the day of the incident, putting the resident at safety risk, which resulted in harm to the resident. The Nurse Manager confirmed that this inaction by the staff jeopardized the health and safety of resident #001.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The scope of the non-compliance is isolated. [s. 19. (1)]

***Additional Required Actions:***

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

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**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. (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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On an identified date, the MOHLTC received complaint intake #024181-17, related to care received at the home for resident #001. The complainant reported that during a visit to the home in two identified months, the complainant found the resident incontinent.

Review of the written plan of care revealed resident #001 wears an incontinent product during the day and night and staff to provide care with each incontinent change.

Interview with PCA #100 revealed that he/she was assigned to provide care to resident #001 on an identified date. PCA #100 reported that he/she approached the resident to be changed at the start of his/her shift, however the resident refused to be changed. PCA #100 reported that he/she waited to return back to assist resident #001 with his/her continence change. Interview with RPN #105 who also worked on the identified date, reported that he/she was informed by the family member of concerns that the resident was incontinent and required to be changed. RPN #105 reported that he/she instructed PCA #100 to change the resident.

Interview with Nurse Manager #102 revealed that the concern was brought forth to him/her from RPN #105, and confirmed that PCA #100 did not follow the plan of care related to resident #001 continence care. [s. 6. (7)]

***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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

Record of the written plan of care for resident #001, revealed that due to resident #001 high risk for falls, he/she requires the use of a safety equipment when up. Record review and staff interview revealed on an identified date, resident #001's safety equipment went missing. Attempts were made to locate the safety equipment, however the safety equipment was not found.

Interview with PSW #104, PSW #103, and RPN #101 revealed that the resident required the use of the safety equipment for safety due to history and high risk for falls.

Interview with OT #108 revealed that he/she received a referral for the missing safety equipment, and assessed the resident for a new safety equipment. The OT reported that an email was sent to the vendor on an identified date, however due to the vendor not available when the email was sent, the resident did not receive a new safety equipment in a timely manner.

Interview with Nurse Manager #108 confirmed that the resident did not have the safety equipment for 26 days, which posed a safety risk to the resident. The Nurse Manager confirmed that the safety equipment was not readily available to meet the resident's care needs. [s. 44.]

***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 ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.***

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**

**Issued on this 11th day of January, 2018**

**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) :** | NICOLE RANGER (189), CECILIA FULTON (618) |
| **Inspection No. / No de l'inspection :** | 2017_659189_0024 |
| **Log No. / No de registre :** | 024181-17 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jan 10, 2018 |
| **Licensee / Titulaire de permis :** | City of Toronto<br>55 JOHN STREET, METRO HALL, 11th FLOOR,<br>TORONTO, ON, M5V-3C6 |
| **LTC Home / Foyer de SLD :** | KIPLING ACRES<br>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) (b)

**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 :**

The licensee shall prepare, submit and implement a plan to ensure that resident #001 is protected from neglect by staff.

The plan shall include, but is not limited to the following:

a) Develop and implement steps to ensure that resident #001 and all residents in the home are protected from neglect by the staff, including training and/or retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, and training related to the requirements to provide care to all residents, as identified in their plan of care.
b) Provide education to direct care staff regarding falls prevention safety requirements for resident #001, the types of safety interventions used for resident #001, and a review of the criteria for the use of each safety intervention.
c) Develop and implement a schedule to test and monitor staff compliance with the home's abuse policies with focus on neglect.
d) Maintain a record of who completed the required retraining, when the retraining was completed and what the retraining entailed.

Plan to be submitted via email to cecilia.fulton@ontario.ca by January 26, 2018

**Grounds / Motifs :**

1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

Under O. Reg. 79/10, s. 5 for the purpose of the definition of "neglect" in the Act and Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being,

and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more resident.

On an identified date, the home submitted a Critical Incident System (CIS) to the Ministry of Health and Long Term Care (MOHLTC) reporting an incident that caused an injury to resident #001, which the resident was taken to hospital and resulted in a significant change in the resident's health status.

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The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The scope of the non-compliance is isolated. (189)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 09, 2018

## 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  10th  day of January, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

**Name of Inspector /**
**Nom de l'inspecteur :** NICOLE RANGER

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