Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2020	2020_526645_0008	015895-20, 017769-20, 019146-20	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor Toronto ON M4W 3L4

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

DEREGE GEDA (645)

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): November 3, 4, 5, 6, 9, 10, 12 and 13, 2020.

This inspection was completed to inspect upon the following intake logs:
#015895-20 - for Critical Incident System (CIS) report number, M545-000034-20,
#017769-20 - for CIS report number, M545-000037-20, and
#019146-20 - for CIS report number, M545-000039-20, all related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT) and residents.

During the course of the inspection, the inspectors observed provision of care, reviewed records including but not limited to relevant training records, policies and procedures, meeting minutes, resident's clinical health records, schedules and investigative notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

- **1 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	Légende 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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A critical incident system (CIS) report was received by the Ministry of Long-Term Care (MLTC) regarding an incident of fall. The report indicated that resident #003 fell from their mobility device sustaining multiple injuries and required hospitalization.

Record review of the home’s investigation note indicated that a PSW was operating the mobility device when the resident fell out off the mobility device. Review of the resident's plan of care indicated that the resident required a specific type of intervention to prevent fall while using the mobility device.The note indicated that the PSW did not implement the required intervention when assisting the resident in their mobility device which resulted in a fall.

During an interview with the PSW, they indicated that they did not implement the required intervention as indicated in the plan of care.

During interview with the DOC, they reiterated that the plan of care outlines specific care needs of each resident, and staff members are expected to provide care as specified in the plan of care.

Sources: resident's plan of care and progress notes, post fall investigation records and interviews with the PSW and DOC. [s. 6. (7)]

2. The licensee has failed to ensure that when resident #001 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A review of a CIS report submitted to MLTC indicated that resident #001 had an unwitnessed fall sustaining an injury.

Review of the progress notes indicated that the resident had multiple fall incidents in April, May, June and July, 2020. The resident's plan of care was updated with fall prevention interventions in April 2020, after the first fall incident. The plan of care was not updated, interventions were not evaluated for effectiveness and new interventions were not implemented when the resident fell in May, June and July, 2020.

The DOC reiterated that recurring falls are the result of unmet or ineffective interventions, and requires reassessment to prevent further fall incidents and injuries.

Sources: resident’s plan of care and progress notes, post fall assessment records and interview with the DOC. [s. 6. (11) (b)]

3. The licensee has failed to ensure that when resident #002 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A review of a CIS report submitted to MLTC, indicated that resident #002 had an incident of fall sustaining an injury.

Review of the clinical notes indicated that the resident had multiple fall incidents between the months of July and September 2020. Review of the post fall assessments indicated that the home identified the antecedent causes of fall for all the incidents, but the plan of care was not evaluated for effectiveness or updated with new interventions to prevent recurring falls.

The clinical notes indicated that the resident had a health condition that made them prone to fall. Interdisciplinary assessment was completed and recommendations were made to prevent recurring falls in July 2020. The home did not include and update the plan of care with these interventions until September 2020. The plan of care was not evaluated for effectiveness when the resident had multiple recurring falls.

The NM reiterated that recurring falls are the result of unmet or ineffective interventions, and requires reassessment to prevent further fall incidents and injuries.

Sources: resident's plan of care and progress notes, post fall assessment records, vital sign records and interviews with the NM and DOC. [s. 6. (11) (b)]

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 care set out in the plan of care is provided to the resident as specified in the plan of care, and that when a resident is reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 23rd day of December, 2020

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

Original report signed by the inspector.