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
Aug 25, 2021	2021_833763_0016	010027-21, 010181-21, 011530-21, 011830-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street 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

IANA MOLOGUINA (763)

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): August 5-6, 9-12, 2021.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

- One intake was related to an unexpected death.
- Three intakes were related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nursing Managers (NM), Occupational Therapist (OT), Registered Dietitian (RD), coroner, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provisions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report indicating that the resident fell and sustained significant injury.

Inspector #763 observed the resident in their room with a falls intervention in place. They had several interventions implemented to manage their falls risk in their plan of care, however their written care plan did not include this intervention.

Staff indicated that each resident’s plan of care encompassed their written care plan, and if residents required the intervention above to be implemented to manage their falls risk, staff were expected to list this in the resident’s written care plan to clearly indicate their care needs. The inspector observed the resident on two other occasions where the intervention was not implemented when it should have been.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan, assessments), CIS report, observations, staff interviews (PSW #103, RPN #108, RN #110, and NM #113). [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

The MLTC received a CIS report indicating that the resident had a fall that resulted in significant injury. They were at risk for falls and had several falls interventions implemented as part of their plan of care after they returned from the hospital.

The inspector observed the resident and confirmed that the resident used a falls intervention to alert staff if they attempted to self-transfer. The resident’s written care plan did not include this intervention.

Staff indicated that each resident’s plan of care encompassed their written care plan, and if residents used this intervention to manage their falls risk, staff were expected to list it in the resident’s written care plan to clearly indicate their care needs. Staff also initiated a Point of Care (POC) task that needed to be completed daily to indicate that the intervention was in good working order. Staff indicated the POC task acted as a reminder to staff that this intervention was to be used for the resident and that its functionality needed to be monitored routinely. Staff confirmed that the current plan of care for the resident was unclear.

Sources: resident clinical records (PointClickCare profile, progress notes, assessments, care plan), CIS report, observations, staff interviews (PSW #109; RPN #108 and #102; and NM #112). [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

The MLTC received a CIS report indicating that the resident had a fall that resulted in significant injury. They were at risk for falls. The Occupational Therapist (OT) assessed the resident after they returned from the hospital and recommended staff implement an intervention to manage their falls risk that helped decrease the likelihood that they would self-transfer without calling for staff assistance. Since arriving back from the hospital, the resident experienced two more falls after attempting to self-transfer.

The resident continued to self-transfer without calling for staff assistance after they returned from the hospital, which put them at risk of further falls. Several staff indicated that the falls intervention recommended by the OT was not trialed for the resident but believed it needed to be trialed as the resident continued to self-transfer and often called out to use the washroom. Staff were not aware that the OT recommended this intervention.

The OT indicated that they followed up with staff after assessing the resident post hospital but did not further review the need for the intervention after speaking with staff. There was no record of this review in the resident's chart. The OT confirmed that this intervention was never trialed or implemented for the resident despite their original recommendation.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), CIS report, staff interviews (PSW #109; RPN #102 and #108; OT#114; and NM #112). [s. 6. (4) (a)]

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

The MLTC received a CIS report indicating that the resident fell and acquired significant injury.

The resident had several interventions implemented after hospital admission to manage their falls risk. Inspector #763 observed the resident in their room on two occasions without falls interventions implemented. The staff believed the resident did not require these interventions. The inspector conducted another observation several days after; the resident was now using the falls interventions required as part of their plan of care. The Registered Nurse (RN) for the unit was interviewed and confirmed that the resident required both interventions in place since their re-admission from hospital and that staff failed to ensure the plan of care was followed on the first two observations.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan, assessments), CIS report, observations, staff interviews (PSW #103, RN #110, and NM #113). [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 in ensuring that the written plan of care sets out clear directions to staff and others who provide direct care to residents; that staff collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other; and that the care set out in the plan of care for residents is provided to them as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a family member used proper techniques to assist a resident when they fed them while standing.

Record review indicated that the resident required a texture modified diet with fluid modification due to a medical diagnosis. The resident and their family refused a modified diet and continued to feed the resident despite the risk and recommendations from the home's Registered Dietitian (RD).

The resident's family was observed providing feeding assistance to the resident while standing. Staff in the vicinity were interviewed and indicated that this was a frequent behaviour; they were not sure if the family was educated on safe feeding techniques. The home's management team indicated that interactions with this family member were often contentious.

The home's RD indicated that residents needed to be fed while sitting to decrease the risk of choking during the meal. The RD indicated that there was no record of providing education to the above family member on safe feeding techniques.

Sources: resident clinical records (care plan, PointClickCare profile), observations, staff interviews (PSW #104, RPN #107, ADON #100, RD #111). [s. 73. (1) 10.]

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 in ensuring that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program when residents' hands were not cleaned before and after a meal.

The Public Health Ontario "Best Practices for Hand Hygiene in All Health Care Settings" document (published April 2014) indicated that resident hands were to be cleaned before and after meals, either by using soap and water or Alcohol-Based Hand Rub (ABHR).

Inspector #763 observed lunch meal service where staff failed to offer and encourage residents to use ABHR or wash their hands prior to meal service. At the end of meal service, staff assisted several residents by wiping their mouth and hands with warm wet cloths.

The observed staff confirmed they usually did not clean resident hands prior to meal service because they believed that most residents washed them in their room. Staff admitted that residents were likely to contaminate their hands on the way to the dining room. Staff also indicated that the warm wet cloths used at the end of meal service did not contain any soap or ABHR.

The home’s IPAC lead expected the staff to ensure residents hands were cleaned with ABHR prior to and after all meals when in the dining room. Warm wet cloths were available for residents as an additional service and not a replacement to proper hand hygiene.

Sources: Public Health Ontario, PIDAC: "Best Practices for Hand Hygiene in All Health Care Settings", 4th Edition (published April 2014); observations; staff interviews (PSW #105 and #106, NM #112). [s. 229. (4)]

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 in ensuring that staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post fall assessment required under the home's falls policy was completed for a resident.

O. Reg 79/10, s. 48 (1) required the licensee to ensure a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's falls policy that directed them to complete a Post Fall Assessment Huddle Form that reviewed the root cause, preventive strategies and any plan of care modifications needed after every fall.

The resident experienced a fall due to a medical emergency. Staff responded to the medical emergency but confirmed that they failed to complete a post fall assessment after the fall occurred.

Sources: resident clinical records (PointClickCare profile, care plan, progress notes, assessments), Policy RC-0518-21 "Falls Prevention and Management" (published January 2, 2020), staff interviews (RN #102 and NM #112). [s. 49. (2)]

Issued on this 26th day of August, 2021

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

Original report signed by the inspector.