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
Jul 5, 2021	2021_833763_0012	022364-20, 024296-20, 000522-21, 001299-21, 002054-21, 003590-21, 005722-21, 006588-21, 006828-21	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): June 7, 8, 9, 14, 15, 16, 18, 20, 21, 22, 23, and 24, 2021.

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

- One intake was related to alleged improper treatment,
- One intake was related to an injury of unknown cause,
- One intake was related to alleged abuse, and
- Six 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), Acting Building Services Manager, Physiotherapist (PT), Occupational Therapist (OT), Registered Nurses (RN), Registered Practical Nurses (RPN), housekeeping staff, and Personal Support Workers (PSW).

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 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. (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 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 detailing a fall of a resident that resulted in significant injury. They were at risk for falls and had several falls interventions listed in their care plan.

The inspector observed the resident's room and confirmed that the resident used a falls intervention that was not included in their care plan. There was also no recent documentation to indicate that this falls intervention was currently being used to manage the resident's falls.

The home's falls policy indicated that the Registered Nurse (RN) or Registered Practical Nurse (RPN) was responsible to update the resident's care plan and monitor implementation once individualized strategies were formulated to manage the resident's risk of falls.

Interviews with staff indicated that each resident's plan of care encompassed their current care plan and required all specified interventions to manage their falls risk to be listed to clearly indicate to staff the resident's care needs. Staff also initiated a Point of Care (POC) task that needed to be completed daily to indicate that the intervention was used and in good working order. Staff indicated that there was no POC task initiated for this intervention which made it unclear to staff what interventions were in place to manage the resident's falls risk.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), CIS report, home observations, "Falls prevention and management" policy #RC-0518-21 (published January 2, 2020), staff interviews (PSW #135, RPN #134, RN #136 & RN #128). [s. 6. (1) (c)]

2. 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 regarding a resident who sustained a significant injury of unknown cause that resulted in a hospital transfer. Staff on duty reported that the resident was unable to weight bear and complained of pain. The home conducted an investigation of the incident and discovered that the day before staff first reported the resident's change in condition, the resident's direct care staff noted a change in the resident's transfer status and reported it to the nurse on duty who denied knowing about the status change.

Record review and staff interviews confirmed that the resident required some assistance for transfers and were able to weight bear. The day before the incident, Personal Support Worker (PSW) #137 discovered that the resident was unable to bear weight and asked PSW #144 to help transfer the resident by using a mechanical device which was new for the resident. PSW #137 then communicated the resident's change in status to the nurse on duty who denied receiving the update. It was not until the following day when other staff also noticed a change in the resident's weight bearing status that staff assessed the resident.

Sources: clinical records (PointClickCare profile, progress notes, care plan), CIS report, home’s investigation notes, staff interviews (PSW #137, RPN #127, NM #133). [s. 6. (4) (a)]

3. The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

The MLTC received a CIS report regarding a fall of a resident that resulted in significant injury and a transfer to hospital.

Record review and staff interviews indicated that the resident frequently paced around the unit and often self-transferred without asking for staff assistance. Approximately a month prior to the fall, they became ill and their typical habits changed. They spent more time in bed and walked less but continued to self-transfer without calling for staff assistance. On the day of the fall, staff heard a bang and found them on the floor after attempting to self-transfer.

The resident's clinical records and staff interviews indicated that the resident's falls interventions were not reassessed after their condition changed and they stopped being as mobile around the unit. Staff indicated that additional falls interventions could have been considered to better alert staff of resident movements when they self-transferred as this was still a common behaviour and required routine monitoring. It was not until the resident fell that staff reassessed the resident's falls interventions and concluded that additional interventions were required to manage the resident's falls risk.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), CIS report, staff interviews (PSW #140, RPN #139, NM #128, NM #133). [s. 6. (10) (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 in ensuring that staff collaborate with each other so that their resident assessments are integrated, consistent with and complement each other; and that residents are reassessed and their plan of care reviewed and revised when their care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #137 and #144 used safe transferring techniques when assisting a resident.

The MLTC received a CIS report regarding a resident who sustained a significant injury of unknown cause that resulted in a hospital transfer.

Record review and staff interviews confirmed that the resident required some assistance for transfers and were able to weight bear. The day before the incident, Personal Support Worker (PSW) #137 discovered that the resident was unable to bear weight and asked PSW #144 to help transfer the resident by using a mechanical device which was new for the resident. PSW #137 then communicated the resident's change in status to the nurse on duty who denied receiving the update.

The home’s transfer policy indicated that, prior to commencing any transfer, staff were expected to review the resident’s care plan to ensure the recommended procedure was still appropriate, and if not, to notify the RN/RPN for reassessment.

Staff confirmed that PSW #137 and #144 should have communicated the change in transfer status to the nurse on duty prior to commencing the transfer to decrease the risk of injury.

Sources: clinical records (PointClickCare profile, progress notes, care plan), CIS report, home’s investigation notes, "Transferring a resident" policy RC-0522-15 (published January 1, 2019), staff interviews (PSW #137, RPN #127, NM #133). [s. 36.]

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 use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

The MLTC received a CIS report regarding a fall for a resident that resulted in significant injury and a transfer to hospital.

The home's Occupational Therapist (OT) assessed the resident five days after their admission and determined that they benefited from several falls interventions to manage their risk. The OT was interviewed and recalled that on the same day of their assessment, they ensured that several interventions were implemented on their shift. Later in the evening, staff found the resident on the floor with their back against the bed. Record review did not indicate whether any falls interventions were used at the time of the fall.

Documentation records were reviewed for the time period and indicated that staff began documenting the use of several falls interventions after the resident returned from hospital admission and additional falls risk assessments were completed.

Staff interviewed could not recall whether the resident was using the above falls interventions at the time of the incident. They admitted that they should have documented all the resident's falls interventions and their responses to the interventions during the incident for a more accurate representation of their condition at the time of the fall.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan, POC records), CIS report, staff interviews (RPN #141, RPN #138, OT #143). [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was dressed in clean and appropriate clothing.

The MLTC received a CIS report alleging abuse and improper care of a resident based on a family complaint submitted to the home. Prior to picking up the resident for a trip, the resident's family found them wearing severely torn clothing and the resident being dirty as a result.

Staff indicated that the resident had a limited supply of clothes to wear and confirmed that it was unacceptable that the resident wore torn clothing that day.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), CIS report, home's investigation notes, staff interviews (RPN#130, NM #128). [s. 40.]

Issued on this 7th day of July, 2021

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

Original report signed by the inspector.