Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 01, 2022	
Inspection Number: 2022-1562-0001	
Inspection Type: Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Kipling Acres, Etobicoke	
Lead Inspector Adelfa Robles (723)	**Inspector Digital Signature** Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2022.12.02 14:01:30 -05'00'
Additional Inspector(s) Ivy Lam (646) Rajwinder Sehgal (741673) Henry Chong (740836)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 2-4, 7-10 and 14-17, 2022

The following intake(s) were completed:

- Intake #00003069 (CIS #M545-000035-21), Intake #00001175 (CIS #M545-000042-22), Intake #00006343 (CIS #M545-000010-22), Intake #00012375 (CIS #M545-000065-22), Intake #00007731 (CIS #M545-000055-22) were all related to physical abuse
- Intake #00001598 (CIS #M545-000031-21), Intake #00003519 (CIS #M545-000030-21), Intake #00003936 (CIS #M545-000029-21), Intake #00011376 (CIS #M545-000062-22), Intake #00004432 (CIS #M545-000046-22) were all related to neglect
- Intake #00005843 (CIS #M545-000049-22), Intake #00001499 (CIS #M545-000046-21) and Intake #00006289 (CIS #M545-000045-21), were all related to injury with significant change
- Intake #00007101 (CIS #M545-000017-22), Intake #00001156 (CIS #M545-000037-21), Intake #00001553 (CIS #M545-000048-21), Intake #00002915 (CIS #M545-000018-22), Intake #00004063 (CIS #M545-000016-22), Intake #00004611 (CIS #M545-000003-22), Intake #00004748 (CIS #M545-000004-22), Intake #00004777 (CIS #M545-000044-21), Intake #00005462 (CIS #M545-000038-21), Intake #00005835 (CIS #M545-000051-21), Intake #00005836 (CIS #M545-000005-22), Intake #00005895 (CIS #M545-000008-22), Intake #00006215 (CIS #M545-000009-22), Intake #00007186 (CIS #M545-000029-22) were all related to falls.

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- Intake #00001046 (CIS #M545-000012-22) related to responsive behaviours

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Food, Nutrition and Hydration
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management
Responsive Behaviours
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (9) (1)

The Licensee has failed to ensure that the provision of care for a resident was documented as set out in their plan of care.

Rationale and Summary
A resident had a history of responsive behaviours. The Behavioural Support Ontario (BSO) staff member recommended a specific intervention to manage their behaviours. This specific intervention was not indicated in the resident's plan of care.

The BSO staff member and Nurse Manager (NM) acknowledged that the specific intervention was implemented but was not indicated in the resident's plan of care. Both stated that the nursing team was expected to update the resident's plan of care.

Failure of the home to update a resident's plan of care related to their responsive behaviours increased the risk of staff not becoming aware of the interventions related to their responsive behaviours.

Sources: Review of resident's clinical records and staff interviews.

[741673]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 23 (2)

The licensee has failed to ensure that the results of every investigation undertaken for every alleged, suspected, witnessed, or reported incident of neglect to a resident was reported to the Director.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) regarding alleged resident neglect. The home completed their investigation but did not report the outcome of the home's investigation to the Director.

The home stated they missed to update the CIS report to indicate the outcome of the investigation to the Director.

Sources: Home's investigation records, CIS report and staff interviews.

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WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that allegations of abuse and/or neglect related to residents were reported immediately to the Director.

Rationale and Summary
a) A resident was discovered with a restraint applied. The staff member did not report the incident to anyone immediately and submitted a note to the NM.

The NM stated they were not made aware of the incident until two days after and reported the incident to the Director. Staff interviews indicated that suspected or alleged abuse and/or neglect must be reported immediately.

Sources: CIS report, home's investigation notes and staff interviews.

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b) The home received an email regarding alleged neglect of a resident. Progress notes indicated that the resident was found in distress.

Staff stated they did not report the incident to anyone immediately and did not follow the correct protocol when reporting the incident. The home was not made aware of the incident until two days after and the incident was reported to the Director.

Sources: CIS report, home's investigation notes and staff interviews.

[740836]

c) A CIS was submitted to the Director regarding alleged resident physical abuse.

The home confirmed that the incident was reported three days later to the Director through the MLTC After-hours reporting system and was supposed to be reported immediately.

Sources: Resident's clinical records, CIS report and staff interviews.

[741673]

d) A CIS was submitted to the Director regarding alleged physical abuse.

The NM confirmed that the incident about resident abuse resulting in harm should have been reported to the Director on the same day it allegedly occurred.

Failure of the home to notify the Director immediately about the witnessed or alleged abuse and/or neglect of residents prevented the Director from responding as required.

Sources: Resident's clinical records, CIS report and staff interviews.

[741673]

WRITTEN NOTIFICATION: Care Plans and Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 24 (1)

The licensee has failed to ensure that a 24-hour admission care plan was developed for a resident.

Rationale and Summary
The home submitted a CIS report to the MLTC regarding alleged resident neglect. A resident was admitted to the home with a specified diagnosis requiring treatment.

Review of the home's policy indicated, registered nursing staff shall develop and maintain a process for the completion of a care plan within 24-hours of resident admission. The resident's interventions related to a specified treatment were initiated two days post admission.

The DOC (Director of Care) and staff member stated that resident's plan of care should have been completed within 24-hours upon admission.

Failure of the home to complete a resident's written plan of care 24-hour post admission increased the risk of delayed continuity of care.

Sources: 24-Hour Admission/Readmission Care Plan published 01-06-2021 RC-0505-01, resident's clinical records and staff interviews.

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WRITTEN NOTIFICATION: General Requirements for Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 30 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and resident response to interventions were documented.

Rationale and Summary
The home submitted a CIS report related to a resident found on restraint. Resident's clinical records revealed that there was no documentation related to the incident.

The home completed an investigation and revealed that the staff restrained the resident inappropriately. The physician examined the resident for any injuries. Registered staff observed the resident for altered skin integrity but did not document their assessment.

Staff member stated that assessments should have been completed on the same day and documented in the incident report. The DOC stated that a Head-to-Toe assessment should have been completed and the registered staff involved failed to document any assessment or completed any documentation post incident.

There was a risk to a resident's health and safety when their assessments, reassessments and response to interventions were not documented, as there were no further actions to monitor the resident and provide appropriate interventions as required.

Sources: Resident's clinical records, investigation notes and staff interviews.

[740836]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with s. 53 (4) (c) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 58 (4) (c) of O. Reg. 246/22, under the Fixing Long Term Care Homes (FLTCA) Act 2021

On April 11, 2022, the FLTCA 2021 and O. Reg 246/22 came into force, which repealed and replaced the LTCHA 2007 and O. Reg 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 53 (4) (c) of O. Reg 79/10. Non-compliance with the applicable requirement also occurred after the April 11, 2022, which falls under s. 58 (4) (c) of O. Reg 246/22 under the FLTCA.

1.Non-compliance with: O. Reg. 79/10, under the LTCHA 2007, s. 53 (4) (c)
The licensee has failed to ensure that when residents demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions were documented.

Rationale and Summary
The home's policy indicated that a resident shall be assessed for new or escalating behavioural response using Dementia Observation System (DOS) monitoring tool as a component of the assessment.

A resident had multiple responsive behaviours. The DOS monitoring tool was initiated after an incident and missing DOS entries were noted on the monitoring tool.

BSO staff member and NM acknowledged that the DOS monitoring tool had missing entries. The NM indicated that the tool should have been completed throughout the monitoring process.

Sources: Behavioural Assessment Tool: Modified Dementia Observation System (DOS) Policy RC-0517-07, resident's clinical records and staff interviews.

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b) A resident had a physical altercation with another resident. The DOS monitoring tool was not initiated for the resident.

The NM acknowledged that the DOS monitoring tool was not initiated post incident. The NM indicated that the tool should have been initiated for any new or escalating resident's behaviour.

Failure to complete and initiate the DOS monitoring tool for the residents increased the risks that behavioural patterns were not accurately captured to support the residents care needs.

Sources: Behavioural Assessment Tool: Modified Dementia Observation System (DOS) Policy RC-0517-07, resident's clinical records and staff interviews.

[741673]

2. Non-compliance with: O. Reg. 246/22, under the FLTCA 2021, s. 58 (4) (c)
The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions were documented.

Rationale and Summary
The home submitted a CIS report to MLTC regarding alleged resident to resident physical abuse.

Review of the home's policy indicated; staff should document results of DOS analysis in the progress notes. A resident was monitored related to their responsive behaviour using the DOS monitoring tool. The BSO-DOS Worksheet was not completed for the resident to indicate the analysis and review of the data collected from the DOS monitoring record.

BSO staff member stated that the review and analysis of the completed DOS monitoring tool was not completed for the resident. The DOC stated that after staff complete the daily DOS-monitoring record, the BSO staff member and the nursing team were expected to collect and review the DOS monitoring tool to come up with strategies for the resident.

Because the resident's DOS monitoring tool was not reviewed and analyzed, the data collected was not utilized by the home to identify contributing factors and modifiable variables associated with the resident's behaviours.

Sources: Behavioural Assessment Tool: Modified Dementia Observation System (DOS) Published 15-09-2022 RC-0517-07, residents clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that a resident who sustained an altered skin integrity, received immediate treatment and interventions to promote healing, and prevent infection.

The home's skin and wound prevention and management policy indicated that if there was evidence of altered skin integrity, the registered staff were to implement immediate treatment and intervention to promote healing. They were also to initiate a referral to the physician and update the care plan regarding the treatment plan.

Rationale and Summary
A resident was found with an altered skin integrity. Staff assessed the resident and applied treatment. A referral to the physician was not made. The treatment was not entered in into the electronic Treatment Administration Record (eTAR), and an assessment was made six days after.

Staff indicated that the treatment order and initial assessment was not completed when the resident's altered skin integrity was discovered. The Skin and Wound Lead indicated that the staff should have informed the physician for treatment order and further treatment should not have been delayed.

There was a risk of infection and delayed healing when a resident's altered skin integrity did not have further treatments applied to promote healing until a few days after it was initially discovered.

Sources: Skin Care and Wound Prevention and Management RC-0518-02, staff interviews, resident's clinical records, resident observations and interactions with staff/co-residents.

[646]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident who sustained an altered skin integrity was reassessed at least weekly by a member of the registered staff.

Rationale and Summary
The home's skin and wound prevention and management policy indicated that for a resident who has altered skin integrity, the registered staff were to reassess the wound weekly.

A resident was found with altered skin integrity and the registered staff did not initiate the weekly skin assessment. The resident's wound was reassessed ten days after. Resident's clinical records indicated there was no other weekly wound assessment completed and there was no assessment to indicate when the resident's wound was healed.

Staff stated they should have initiated the weekly wound assessment on the day the wound was discovered. The Skin and Wound Lead indicated that the resident's weekly skin assessments were missed.

There was a risk for delayed treatment and healing for a resident when their wound did not receive weekly assessment until it was healed.

Sources: Skin Care and Wound Prevention and Management RC-0518-02, staff interviews, resident's clinical records, resident observations and interactions with staff/co-residents.

[646]

COMPLIANCE ORDER CO #001 Prohibited Devices that Limit Movement

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 112 7.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with O. Reg 79/10 s. 112 (7). Specifically, the licensee must:

1. Review the contents of the compliance order with all PSWs and registered staff working in a specified unit.
2. Re-educate all PSWs and registered staff working in a specified unit related to the home's restraint policy.
3. Document the education provided, including the content of the material reviewed, the date completed, and the staff member who provided the education.

The licensee has failed to ensure that devices such as sheets, wraps, tensor or other types of strips or bandages used other than for therapeutic purposes were not used in the home.

Grounds
A resident was discovered with a restraint applied. The restraint was released by the physician and the registered staff who discovered the incident while completing their rounds.

The home completed an investigation and revealed that the resident was on restraint for a period and was not capable of releasing the restraint. Investigation notes also indicated that the physician used a tool to release the resident from restraint and concluded that the staff had applied an inappropriate restraint on the resident.

The DOC stated that the staff member was aware that the resident should not had been restrained.

There was risk of harm to a resident's health as the restraint could lead to injury or death.

Sources: Resident clinical records, investigation notes and staff interview.

[740836]

This order must be complied with by January 13, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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