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
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Original Public Report

Report Issue Date: March 9, 2023	
Inspection Number: 2023-1562-0002	
Inspection Type: Follow up 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: 2023.03.15 08:47:01 -04'00'
Additional Inspector(s) Maya Kuzmin (741674)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 16-17, 21-24, and 27-28, 2023

The following intake(s) were inspected:

- Intake: #00012662 – [Critical Incident (CI): M545-000066-22] – related to an injury from an unknown cause
- Intake: #00018258 – [CI: M545-000002-23] – related to improper transfer
- Intake: #00014790 – [CI: M545-000071-22] – related to fall with injury
- Intake: #00014229 – [CI: M545-000068-22] – related to alleged physical abuse
- Intake: #00017450 – [CI: M545-000001-23] – related to alleged physical abuse
- Intake: #00014332 – [CI: M545-000069-22] – related to alleged sexual abuse
- Intake: #00015247 – Follow-up Inspection to a Compliance Order (CO) #001: O. Reg. 79/10 s. 112 (7) – related to Prohibited Devices that Limit Movement

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1562-0001 related to O. Reg. 79/10, s. 112 (7) inspected by Adelfa Robles (723).

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

Falls Prevention and Management
Infection Prevention and Control (IPAC)
Prevention of Abuse and Neglect
Resident Care and Support Services
Restraints/Personal Assistance Services Devices (PASD) Management
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to implement measures in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard).

Specifically, section 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary:

Observations were made to the home on a specified date and revealed four expired Alcohol Based Hand Rubs (ABHRs) on the tables in the worship room located on the second floor. Staff who were present at that time discarded the ABHRs. IPAC Lead acknowledged that expired ABHRs were to be discarded and not to be on the tables.

Sources: Observations on February 16, 2023, IPAC Standard for Long-Term Care Homes, April 2022, and staff interviews.

Date Remedy Implemented: February 16, 2023.

[741674]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee failed to ensure the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of a resident so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary:

A Critical Incident (CI) report was submitted to the Director related to a resident-to-resident sexual abuse. A staff found a resident inappropriately touching another resident.

Review of a resident's records indicated that they exhibited inappropriate sexual behaviours on numerous occasions. Behaviour Support Ontario (BSO) was made involved only after the incident.

A staff verified that the resident had inappropriate sexual behaviors prior to this incident. BSO staff verified that they were not notified of the resident's inappropriate behaviours prior to the incident, hence they were not able to provide interventions or strategies for the nursing team to manage the resident's behaviours. The Director of Care (DOC) verified that a referral to the BSO should had been completed to manage the resident's behaviours.

The lack of integration of assessments between nursing team and BSO placed a resident at moderate risk to assess for further inappropriate sexual responsive behaviours.

Sources: Critical Incident #M545-000069-22, a resident's clinical records and staff interviews.

[741674]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that staff provided care to a resident as specified in their plan of care.

Rationale and Summary

The home submitted a CI report when a resident sustained an injury from an unknown cause.

Review of a resident's clinical records indicated that they require a level of assistance for bathing. The documentation by a staff indicated that the resident required a different level of assistance.

The staff revealed that for bathing, they would provide the other level of assistance that was different from the resident's clinical records. Staff interviews indicated that the resident required the level of assistance identified in their clinical records. All stated that the resident's plan of care was not followed as specified when this staff provided the other level of assistance not identified in the resident's clinical records.

There was a risk and potential injury to a resident when their bathing was not provided as specified in their plan of care.

SOURCES: A resident's clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: DUTY TO PROTECT

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

The licensee has failed to ensure that a resident was protected from sexual abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines sexual abuse as “any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Rationale and Summary:

A CI report was submitted to the Director related to a resident-to-resident sexual abuse. A staff found a resident inappropriately touching another resident and intervened afterwards.

The staff verified that based on the other resident’s completed cognitive assessments, the other resident would not be able to provide consent with any sexual activities.

There was risk to the other resident when they were not protected by the home from sexual abuse by the resident.

Sources: Critical Incident Report #M545-000069-22, a resident’s clinical records, Zero Tolerance of Abuse and Neglect Policy RC-0305-00 (June 2021) and staff interviews.

[741674]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary:

The home submitted a CI report when a resident sustained an injury when staff assisted a resident for a transfer.

Review of the resident's clinical records indicated that they require a level of assistance for transfers.

The home's policy indicated that staff are to safely apply a transfer equipment on the resident with a specific number of staff required for all aspects of the application of the equipment.

Interview with the resident revealed that they remembered the incident. Staff who assisted the resident stated that the other staff prepared the resident independently and was only called for assistance for the actual transfer. The home completed an investigation and acknowledged that staff involved did not follow safe transferring and positioning techniques.

There was actual harm to a resident when staff failed to use safe transferring and positioning techniques.

SOURCES: A resident's clinical records, home's policy NU-0606-00 Mechanical Lifting Device Section 06-Safety, published 01-06-2021, home's policy RC-0522-17 Sling Selection and Application Section 05-Resident Planning Process published 15-05-2021 and staff interviews.

[723]