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: June 21, 2023
Inspection Number: 2023-1562-0003
Inspection Type: Complaint Critical Incident System
Licensee: City of Toronto
Long Term Care Home and City: Kipling Acres, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Kehinde Sangill (741670)	Kehinde Sangill Digitally signed by Kehinde Sangill Date: 2023.07.11 15:23:56 -04'00'

Additional Inspector(s) Trudy Rojas-Silva (000759)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 30, 31, 2023 and June 1, 2, 5-9, 2023.
The following intake(s) were inspected:
• Intake: #00084647 - was related to severe Hypoglycemia resulting in transfer to hospital.
• Intakes: #00087155, #00089175, and #00089569 - were related to complaints regarding alleged neglect and improper care.
• Intake: #00087186 - was related to a complaint regarding dietary services.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

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

Rationale and Summary

A resident was readmitted from the hospital with two areas of altered skin integrity. A referral sent to the Registered Dietitian (RD) did not include information related to skin impairment. A readmission assessment was completed for the resident by the RD the day after readmission with no mention of the newly acquired areas of skin impairment.

The resident was sent back to the hospital two days after returning to the home. The hospital RD implemented a nutritional intervention to promote healing of skin impairment. The nutritional intervention was implemented for the resident upon return from the hospital, five days after the initial RD readmission assessment was completed. The home RD indicated that they were advised of the areas of skin impairment by the hospital RD and were unaware prior.

A Registered Practical Nurse (RPN) verified that the readmission referral sent to the RD did not include information about the skin impairment. The RPN and a Registered Nurse (RN) acknowledged that the RD should have been informed about the skin impairment in the referral.

The home's skin and wound policy required that registered staff refer residents with skin impairment to the RD for nutritional assessment and diet/supplementation orders.

Staff's failure to collaborate with the RD in the care of the resident's skin impairment may have prevented timely implementation of nutritional intervention to promote healing.

Sources: Resident's clinical records, Skin Care and Wound Prevention and Management policy (RC-0518-02, published September 15, 2022); and staff interviews.
[741670]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed ensure that a policy directive that applied to the long-term care home, was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were required to ensure that the masking requirement set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", was followed.

The document required that masks must not be removed when staff are interacting with residents or in designated resident areas.

Rationale and Summary

A Food Service Worker (FSW) was observed setting the table in one of the unit dining rooms wearing their surgical mask under their chin. The FSW acknowledged that the mask should be worn above the nose, but they were eating a piece of chocolate and needed to clear their mouth.

The Infection Prevention and Control (IPAC) Lead stated that staff are required to wear a surgical mask in the resident home areas (RHA) and only eat in designated areas of the home.

Staff's failure to properly don a surgical mask in the RHA increased the risk of transmission of infection to residents and other staff.

Sources: Observations in the home; Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, COVID-19 Guidance Document for Long-Term Care Homes in Ontario; staff interviews. [741670]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident, who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A head to toe assessment was completed for a resident upon readmission from the hospital. The assessment showed two areas of altered skin integrity. Initial skin and wound assessments were not completed for the identified areas of skin impairment.

A RN acknowledged that the resident did not have an initial skin and wound assessment completed for the areas of altered skin integrity. The RN stated that a skin and wound assessment should have been completed with the head to toe assessment when the resident returned from the hospital.

The Nurse Manager stated that the skin and wound assessments are scheduled for a specific day of the week, and staff were not prompted to complete the assessment as the resident was readmitted after that day.

Failure to complete an initial skin and wound assessment for the resident may hinder the ability to evaluate effectiveness of the treatment.

Sources: Resident's clinical records; and staff interviews.
[741670]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 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's altered skin integrity was reassessed at least weekly by a member of the registered staff.

Rationale and Summary

A head to toe assessment completed for a resident upon readmission from the hospital showed two areas of altered skin integrity. An order was initiated for weekly skin and wound assessment. The first skin and wound assessment was completed for the resident 11 days after the order was initiated. The assessment scheduled for the week after the order was initiated was not completed.

A RN and Nurse Manager verified that the skin and wound assessment was not completed at least weekly as clinically indicated. The Nurse Manager stated that the resident was in the hospital on the day that the skin and wound assessment was scheduled. The Nurse Manager acknowledged that the skin and wound assessment should have been completed when the resident returned from the hospital.

The home's Skin and Wound policy indicated that as part of the protocol for skin impairment, registered staff are to assess residents' skin impairment weekly and complete skin and wound assessments.

Failure to complete weekly skin and wound assessment for the resident increased the risk of changes in the skin impairment not being identified and addressed in a timely manner.

Sources: Resident's clinical records, Skin Care and Wound Prevention and Management policy (RC-0518-02, published September 15, 2022); and staff interviews.
[741670]

WRITTEN NOTIFICATION: Food Production

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

The licensee has failed to ensure that all food and fluids in the food production system were served using methods to prevent contamination.

Rationale and Summary

A FSW was observed wearing the same gloves to load dirty and clean dishes in and out of the dishwasher. After handling dirty dishes, the FSW rinsed their gloved hands in a bucket of Mikro Quat solution that held a used towel. The towel was previously used to clean a dirty cart for meal service.

The FSW verified that they cleaned their hands with the same solution and towel used to clean the dirty cart. The FSW indicated that they cleaned the dirty gloves with the used towel and Mikro Quat solution to sanitize the gloves before handling clean dishes.

The Nutrition Manager (NM) stated that staff are required to remove gloves used to handle dirty dishes and perform hand hygiene before handling clean dishes. The NM acknowledged that using gloved hands dipped in Mikro Quat solution posed a risk of cross contamination.

The home's policy on dishwashing requires that staff wash their hands before handling any clean article/item/utensil. The Material Safety Data Set (MSDS) for Mikro Quat indicated that the chemical is harmful if ingested.

The use of dirty gloves cleaned with Mikro Quat solution to handle clean dishes increased the risk of cross contamination.

Sources: Observations in the home; Dishwashing policy (FN-SOP-07, published November 15, 2022), Mikro Quat Safety Data Sheet (Issuing Date April 23, 2020); staff interviews.
[741670]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to hand hygiene.

Rationale and Summary

On a specified day, a FSW was observed handling bread immediately after handling plates, serving spoons, opening drawers, and cleaning counters, without performing hand hygiene.

The following day, another FSW was observed holding cups around the rim with their finger inside the drinking surface while dispensing ice. The FSW acknowledged they did not perform hand hygiene before handling clean dishes and serving ice and fluids to the residents.

The NM stated that staff are required to perform hand hygiene between tasks. The NM acknowledged that both FSWs did not follow required IPAC procedure for handling residents' food, clean dishes, and utensils.

The IPAC Lead stated that staff are expected to perform hand hygiene before touching residents' food and clean dishes to minimize risk of contamination and infection.

The home's dishwashing policy identified not touching eating surface of clean cutlery, dishes and glassware as a critical control point. The policy also directed staff to wash their hands before handling any clean article/item/utensil.

Staff's failure to perform hand hygiene before handling food and clean dishes increased the risk of infection.

Sources: Observations in the home; Dishwashing policy (FN-SOP-07, published November 15, 2022); staff interviews.
[741670]

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that written responses on identified dates, provided to a person who made a complaint to the licensee concerning the care of a resident, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

Written concerns regarding the care of a resident were received by the licensee on identified dates. The home responded to these concerns in writing.

The response letters did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

The Director of Nursing (DON) stated that the home usually included the above-mentioned information but failed to do so in this instance.

Sources: Review of the response letters; and Interview with DON.
[741670]

WRITTEN NOTIFICATION: Emergency Drug Supply

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 132 (b)

The licensee has failed to comply with maintaining an emergency drug supply regarding access to Glucagon during a resident's severe hypoglycemic episode.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required for the emergency drug supply of a long-term care home; to have a written policy in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply and must be complied with.

Specifically, staff did not comply with the policy "Management of Hypoglycemia", dated September 15, 2022, which addresses the access to Glucagon in the event of severe hypoglycemia.

Rationale and Summary

A resident experienced an episode of severe hypoglycemia where they became unresponsive and was unable to receive treatment by mouth. As per policy, registered staff were required to administer glucagon when a resident is unconscious, unable to swallow, agitated or resistive to oral treatment. A RN did not administer Glucagon because there was none found on the unit.

As a result, the resident's condition worsened and was transferred to the hospital.

Staff's failure to administer glucagon during a severe hypoglycemic episode put the resident at risk for complications of hypoglycemia, and required hospitalization.

Sources: Resident's clinical records, Policy/Algorithm on The Management of Hypoglycemia (policy # MM-0206-00 updated September 15, 2022); Staff interviews.
[000759]

WRITTEN NOTIFICATION: Residents' Drug Regimes

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (b)

The licensee has failed to comply with the appropriate actions taken in response to an incident of severe hypoglycemia and unresponsive hypoglycemia.

Rationale and Summary

A resident experienced an episode of severe hypoglycemia. A RN and RPN both responded to the incident and gave the resident two to three packages of sugar dissolved in juice to treat low blood sugar levels. The resident then became unresponsive and was unable to receive treatment by mouth. Glucagon was not administered as the RN could not find it on the unit.

The licensee's policy "The Management of Hypoglycemia", instructs staff to dissolve four packages of sugar in water and not juice. As well, staff are to administer Glucagon if a resident is unresponsive, unable to swallow, agitated or resistive to oral treatment.

As a result, the resident's condition worsened. The ambulance was called, and paramedics were able to administer Glucagon. However, the resident remained unresponsive and was transferred to the hospital.

Staff's failure to follow the appropriate actions taken in response to a severe hypoglycemic episode put the resident at risk of further complications of hypoglycemia.

Sources: Resident's clinical records, the home's Policy/Algorithm on The Management of Hypoglycemia (policy # MM-0206-00 updated September 15, 2022), staff interviews.
[000759]