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 Licensee Report

Report Issue Date: October 27, 2023.
Inspection Number: 2023-1562-0005
Inspection Type: Complaint Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Kipling Acres, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Trudy Rojas-Silva (000759)	Trudy Rojas-Silva Digitally signed by Trudy Rojas-Silva Date: 2023.11.09 13:12:41 -05'00'

Additional Inspector(s)
Fiona Wong (740849)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 29, 2023, October 3-5, and 10, 2023
The inspection occurred offsite on the following date(s): October 6, 2023.

The following intake(s) were inspected:

- Intake: #00095935 was a complaint related to resident care and support services, skin and wound prevention and management.
- Intakes: #00095561 Critical Incident (CI) #M545-000026-23, #00095967 CI #M545-000028-23, #00095959 CI #M545-000027-23 were related to resident care and support services.
- Intake: #00097226 CI #M545-000032-23 was related to fall prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control

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 (1) (a)

The licensee failed to ensure there was a written plan of care for the resident that sets out the planned care for the resident.

Rationale and Summary

The resident returned from hospital after sustaining a fall.

A fall prevention care plan was revised, however there were no active goals or interventions associated with the care plan.

A staff member stated the care plan should have been updated with goals and interventions within 24 hours of readmission from the hospital.

A staff member indicated that the resident was assessed to be at risk for falls and required falls prevention interventions that should have been documented in their care plan. There were interventions that were implemented for the resident but not captured in the plan of care. As a result, staff members indicated there were inconsistencies in their understanding of what falls prevention interventions were in place for the resident upon return from the hospital.

Nurse Manager (NM) verified that the resident's falls prevention care plan was not updated to reflect the resident's changed needs.

Failure to update the resident plan of care with the relevant fall prevention interventions increased their risk of injury and of not receiving the appropriate care based on their needs.

Sources: the resident's care plan and progress notes, interviews with relevant staff

[740849]

WRITTEN NOTIFICATION: Integration Of Assessments, 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 that the staff and others involved in the different aspects of care for the resident 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 had a change in their ambulation ability and complained of pain.

Records show that a staff member documented that the resident was to be assessed by a physician due to their change in condition.

No assessment request was found in the physician's communication books nor did the progress notes reveal the physician was notified. No evidence of physician assessment was found in the resident's medical chart or progress notes.

Director of Nursing (DON) verified the physician needs to be notified when a resident needs to be assessed.

Failure to collaborate with the physician on assessing the resident when they had a change in condition potentially delayed resident receiving the appropriate treatment.

Sources: interviews with relevant staff, resident progress notes, medical chart, and physician communication books.
[000759]

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 failed to ensure that the resident was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the resident exhibited altered skin integrity.

Rationale and Summary

On a specified date a resident was identified to have multiple altered skin conditions.

The resident's clinical records indicated that the Braden Scale was not completed after the altered skin integrities were identified.

NM verified that the Braden Scale should have been completed.

Failure to complete the Braden Scale when the resident exhibited altered skin integrities put the resident at risk for not receiving the appropriate interventions based on their assessed needs.

Sources: The resident's clinical records, interviews with relevant staff, the Skin Care and Wound Prevention and Management policy.
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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 the resident who exhibited altered skin integrity was reassessed at least weekly.

Rationale and Summary

A resident was identified to have multiple altered skin conditions.

The policy directed staff to reassess all wounds using the Wound Assessment tool at least weekly.

The resident's clinical records showed that there was a missing skin assessment and, it was

verified by the NM that the skin assessments should have been completed weekly on a specified date.
Failure to complete the weekly wound assessments as required increased the risk of not capturing the changes in the resident's altered skin integrity in a timely and appropriate manner, and therefore potentially delaying the implementation of appropriate interventions based on the resident's identified needs.

Sources: The resident's clinical records, interviews with relevant staff, the Skin Care and Wound Prevention and Management policy.
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