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

Original Public Report

Report Issue Date: January 4, 2024
Inspection Number: 2023-1562-0006
Inspection Type: Complaint Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Kipling Acres, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Slavica Vucko (210)	Slavica Vucko Digitally signed by Slavica Vucko Date: 2024.01.04 12:38:30 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 14, 18, 19, 20, 21, 2023
The inspection occurred offsite on the following date(s): December 13, 2023

The following Critical Incident (CI) intake(s) were inspected:
- Intake: #00099012, related to a fall of a resident resulting in injury

The following Complaint intake(s) were inspected:
- Intake: #00101811, complaint regarding skin and wound care.
- Intake: #00103301, complaint regarding improper care, and treatment administration.

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

Skin and Wound Prevention and Management

Resident Care and Support Services
Infection Prevention and Control
Falls 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: FLTCA, 2021, s. 6 (10) (b)

Plan of care

When reassessment, revision is required

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,

(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that resident #002's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and summary

A family member of resident #002 observed that on a specified date, a particular device was inappropriately applied to the resident.

Resident #002's plan of care indicated the resident was to wear the particular device for medical reasons. As per the resident's plan of care, there were instructions for staff on how to apply the device as per the manufacturing manual. These instructions were reassessed by the Occupational Therapist (OT) who then recommended a different method of application.

The OT communicated the new method of device application verbally to registered staff but the written plan of care was not updated.

Failure to revise resident #002's plan of care when their needs changed placed the resident at risk of discomfort.

Sources: Resident #002's written plan of care, interviews with resident #002's family member, and home's staff.