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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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: February 7, 2024

Inspection Number: 2024-1562-0001

Inspection Type:
Complaint
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Kipling Acres, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2024.02.08 14:39:58 -05'00'

Additional Inspector(s)
Joy Ieraci (665)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 18-19, 22-24, 2024.

The following intakes were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00103781 - [M545-000038-23] related to a disease outbreak.
- Intake: #00105154 - [M545-000039-23] related to improper/incompetent treatment of a resident.
- Intake: #00105892 -[M545-000003-24] related to unexpected death of a resident.

The following intake was inspected in the Complaint Inspection:

- Intake: #00104211 related to a resident's care.

The following intake was completed in the CIS Inspection:

- Intake: #00105448 - [M545-000001-24] related to neglect of a resident.

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

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

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)
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applied

to the long-term care home.

On August 30, 2022, Minister's Directive: COVID-19 response measures for long-term care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19. Per section 9 of the Minister's Directive, licensees were required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for (LTCHs) in Ontario were followed.

The COVID-19 Guidance Document for Long-Term Care Homes in Ontario, dated November 07, 2023, stated homes were to post signage at entrances and throughout the home that lists the signs and symptoms of COVID-19, for self-monitoring and steps that must be taken if COVID-19 is suspected or confirmed in any individual.

Rationale and Summary
During initial tour of the home, there was no signage posted at the entrance and throughout the home for passive screening and steps that must be taken if the individual did not pass passive screening. There was signage posted at the entrance titled "Please do your part to prevent infections", however it did not indicate self-monitoring or the steps that must be taken if COVID-19 was suspected or confirmed in any individual.

Infection Prevention and Control (IPAC) Lead acknowledged that there was no signage posted at the entrance or any other part of the home outlining signs and symptoms related of COVID-19 for self-monitoring.

On January 22, 2023, the IPAC Lead #111 posted signage at the entrance of the

home and different areas of the home which listed signs and symptoms of COVID-19 and also indicated if anyone exhibiting symptoms was not to enter the home.

Failure to post signage at entrance and throughout the home that lists the signs and symptoms of COVID-19 for self-monitoring increased the risk of infection transmission.

Sources: Observation, COVID-19 guidance document for long-term care homes in Ontario dated November 2023, Minister's Directive: COVID-19 response measures for long-term care homes dated August 2022, and interview with IPAC Lead.

[741673]

Date Remedy Implemented: January 22, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's right to be afforded privacy in treatment was fully respected and promoted.

Rationale and Summary

Nurse Manager (NM) acknowledged that one of the resident's treatment information was shared with another resident's Power of Attorney (POA). Director of Care (DOC) also confirmed that based on the home's investigation, it was substantiated that there was a privacy breach where staff had shared resident's personal care information and the resident's right to be afforded privacy in treatment was not respected.

Failure to provide the resident with privacy prevented them from receiving care in a dignified and respectful manner.

Sources: Complaint, interviews with NM and DOC.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's POA was given the opportunity to participate fully in the development and implementation of the plan of care when new treatment was ordered for the resident.

Rationale and Summary

A resident was noted to have responsive behaviours. The resident was assessed by

Psycho-geriatrician and recommended to initiate a treatment. The resident was seen by in-house physician and order was given to start the treatment. The resident's records indicated that the treatment was administered to the resident. In review of the resident's progress notes, there was no POA notification documented related to the resident's new treatment.

The NM acknowledged that staff were expected to inform resident's POA before initiating a treatment and acknowledged that the resident's POA was not given the opportunity to participate fully in the development and implementation of the plan of care when new treatment was prescribed.

Failure to notify the resident's POA regarding the new treatment prevented them from fully participating in the plan of care.

Sources: Resident's clinical records, and interview with NM.

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WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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; or

The licensee has failed to ensure that the resident was reassessed and their plan of care reviewed and revised when their care needs changed.

Rationale and Summary
The resident was assessed by the Physiotherapist and recommended specific assistance for transfers.

Record Review of the resident's care plan reflected that specific assistance for transfer was not updated in the care plan after the resident was assessed by the physiotherapist.

The Physiotherapist acknowledged that the resident required specific assistance for transfers and that their care plan was not updated after they were assessed. Personal Support Worker (PSW) stated that they provided specific transfer assistance to the resident which was not consistent with the physiotherapist recommendation for transfer. NM acknowledged that the resident's care plan was not updated to reflect the change in their transfer status.

Failure to update the plan of care in relation to the resident's transfers placed them at risk for injury.

Sources: Resident's clinical records, interviews with Physiotherapist, PSW, NM and other staff.

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WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to comply with the housekeeping procedures for cleaning and disinfection of contact surfaces in the resident's room.

Rationale and Summary
The home's policy "Guidelines for Cleaning and Disinfection" indicated that all horizontal surfaces should be cleaned daily and high touch surfaces (i.e., medical equipment, doorknobs, call bells) should be cleaned frequently.

Observation of cleaning and disinfecting of frequently touched surfaces in the resident's room completed on Humber's Resident Home Area (RHA), showed that the housekeeper did not clean the high touch areas in one of the resident room.

The housekeeper acknowledged that they did not clean the high touch areas in the resident's room as required. The home's Building Service Manager (BSM) stated that the high touch areas should have been cleaned daily when the home was not in an outbreak. They confirmed that high touch contact surfaces in resident rooms were not disinfected daily.

By not ensuring that cleaning procedures for high touch surfaces in one of the resident rooms were followed increased the risk of spreading harmful

microorganisms throughout the home.

Sources: Observation of cleaning and disinfecting of resident's room, the home's policy "Guidelines for Cleaning and Disinfection" IC-0901-00 last revised in January 2021, and interviews with housekeeper, and BSM.

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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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented. Specifically, Sections 9.1, "the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program", including the four moments of hand hygiene.

Rationale and Summary
PSW was observed physically assisting a wheelchair-dependent resident to the dining room for meal service. As another resident entered the dining room with a walker, the PSW positioned the wheelchair-dependent resident at the side of the dining table and assisted another resident to a seating position. The PSW did not perform hand hygiene in between resident interactions and prior to applying

clothing protector on one of the residents.

The home's policy titled "Hand Hygiene" indicated hand hygiene should be performed before/after contact with resident/client and touching furniture/equipment in the resident/client environment.

The PSW acknowledged that they did not perform hand hygiene in-between assisting residents to the dining room. IPAC Lead acknowledged that staff did not implement appropriate hand hygiene practice.

Failure to ensure hand hygiene was performed according to routine practices increased the risk of infectious disease transmission.

Sources: Dining observation, IPAC Standard for LTCH's last revised April 2022, Home's hand hygiene policy #IC-0606-01, dated January 2021, interviews with PSW and IPAC lead.

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