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: May 13, 2024

Inspection Number: 2024-1562-0002

Inspection Type:
Complaint
Critical Incident (CI)

Licensee: City of Toronto

Long Term Care Home and City: Kipling Acres, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2024.05.14 12:51:17 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23, 25, 26, 29, 30, 2024 and May 1, 3, 8, 2024
The inspection occurred offsite on the following date(s): May 9, 2024

The following intake(s) were inspected:

- Intakes: #00109406-(CI); #00110104 (CI) and #00109440-(Complaint) related to allegation of abuse and neglect, retaliation, palliative care, skin and wound and personal support services.
- Intake: #00114034-(CI) related to a fall with injury.

The following intake was completed in the inspection:

- Intake: #00109700- (CI) related to a fall with injury.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Palliative Care
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident, unless prescribed.

Rationale and Summary

A resident sustained altered skin integrity and received treatment. The home's protocol for the altered skin integrity was to apply a specific treatment. However, a registered nurse (RN) treated the area with a drug, which was not prescribed for the resident.

The RN and a Nurse Manager (NM) acknowledged that the drug was administered without being prescribed for the resident.

The administration of the drug posed a potenital risk to the resident's altered skin integrity's healing process.

Sources: Review of a resident's clinical records, home's investigation notes, New Impaired Skin Integrity Protocol; and interviews with an RN, NM and other staff. [665]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Conduct weekly audits for three weeks to ensure fall interventions for a resident are implemented upon service of this report.

2) Maintain a record of the audits conducted, the auditor, dates of the audits, results of the audits and any actions taken to address the audits' findings.

3) Provide a review of a resident's plan of care related to falls prevention and management to a specified Personal Support Worker (PSW), and other PSW staff that are regularly assigned to the resident upon service of this report.

4) Maintain a record of the review conducted, date(s) of the review and the staff that participated in the review.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in the plan.

1) Rationale and Summary

A resident had a fall, resulting in significant injuries and a change in the resident's health status.

The plan of care required staff to place an intervention when the resident was in bed. However, at the time of the fall, the intervention was not in place.

The assigned PSW provided care to the resident and, while disposing of soiled linens and incontinence products, a co-resident required assistance. The PSW provided care to the co-resident without placing the intervention beside the resident's bed. Subsequently, the resident was discovered on the floor with injuries, and the PSW admitted to not placing the intervention as per the plan of care in the home's investigation and to the inspector.

A NM acknowledged that the PSW failed to adhere to the resident's plan of care.

The absence of the intervention as per the plan of care may have contributed to the significant injuries sustained by the resident following the fall.

Sources: Review of CI report, a resident's clinical records and investigation notes; and interviews with a PSW, NM and other staff. [665]

2) Rationale and Summary

A resident was transferred with a mechanical lift by two PSWs. The plan of care did not direct staff to use a mechanical lift for transfers.

A PSW acknowledged they used the mechanical lift to transfer the resident due to the resident's responsive behaviour.

A registered practical nurse (RPN) and a NM acknowledged that the PSWs did not follow the plan of care for the resident by using the mechanical lift.

Using the mechanical lift to transfer the resident posed a risk of injury.

Sources: Review of a resident's clinical records; and interviews with a PSW, RPN and NM. [665]

This order must be complied with by July 2, 2024

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.