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: November 21, 2024

Inspection Number: 2024-1562-0004

Inspection Type:
Complaint
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Kipling Acres, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12 to 15 and 19 to 20, 2024
The inspection occurred offsite on the following date(s): November 18, 2024

The following intake(s) were inspected:

- Intake: #00126044 / Critical Incident (CI) #M545-000039-24 was related to the outbreak of a communicable disease
- Intake: #00127966 / CI #M545-000044-24 was related to fall of resident resulting in injury
- Intake: #00128324 was a complaint related to multiple aspects of care

The following intakes were completed in this inspection:

- Intake: #00122597 / CI #M545-000032-24 , Intake: #00125680 / CI #M545-000040-24 and Intake: #00126356 / CI #M545-000041-24 were related to fall of resident resulting in injury
- Intake: #00124442 / CI #M545-000036-24 was related to the outbreak of a communicable disease

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

Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

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. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee failed to ensure that the written plan of care for a resident was set out to include a fall prevention intervention.

Rationale and Summary:
A resident fell sustaining an injury. The Occupational Therapist (OT) made a recommendation for a fall prevention intervention.

The resident's plan of care reviewed did not include the fall prevention intervention, however; the intervention was observed to be in place.

During an interview, both Personal Support Worker (PSW) and Registered Practical Nurse (RPN) verified that the fall prevention intervention was not documented in the resident's plan of care. Furthermore; OT confirmed that this intervention should have been documented in the resident's plan of care.

Failure to ensure that the use of fall prevention intervention was included in the resident's plan of care to prevent injury from falls, may cause inconsistent application of the intervention by the staff.

Sources: Observation of resident. Review of resident's clinical records including progress note, care plan and referral form. Interview with PSW, RPN and OT.

Date Remedy Implemented: November 14, 2024

WRITTEN NOTIFICATION: 24-hour Admission Care Plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (3) (b)
24-hour admission care plan
s. 27 (3) The licensee shall ensure that the care plan sets out,
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 246/22, s. 27 (3).

The licensee has failed to ensure that the 24-hour admission care plan provided clear directions for safe meal practices to staff who provided direct care to a resident.

Rationale and Summary:
Prior to the admission, a resident had a Speech-Language Pathologist (SLP) consultation. The SLP had recommended specific safe meal practices.

Review of the resident's 24-hour admission care plan did not identify any direction on safe meal practices for the staff.

PSW, RPN, Registered Nurse (RN), Nurse Manager (NM) and Registered Dietitian (RD) acknowledged that the care plan did not provide clear directions about safe meal practices for the resident.

Failure to ensure that the 24-hour admission care plan provided clear directions for safe meal practices to the staff, increased the risk of aspiration for the resident.

Sources: Review or resident's clinical record including care plan, interview with PSW, RPN, RN, NM and RD.