

**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

## Public Report

**Report Issue Date:** June 6, 2025

**Inspection Number:** 2025-1562-0004

**Inspection Type:**

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): May 29-30, 2025 and June 2-6, 2025

The following intake(s) were inspected:

- Intakes Log #00139497/Critical Incident (CI) #M545-000011-25; Log #00142919/CI #M545-000027-25; Log #00144916/CI #M545-000030-25 - were all related to unwitnessed falls resulting in injury
- Intake Log #00143944/CI #M545-000029-25 - related to a witnessed fall resulting in injury

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

Falls Prevention and Management

## INSPECTION RESULTS

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## **WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES**

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 40**

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices when they manually transferred a resident after a fall incident.

**Sources:** Home's records and staff interviews.