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

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Public Report

Report Issue Date: September 5, 2025
Inspection Number: 2025-1562-0007
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 dates: August 29, and September 2 - 5, 2025.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00151890 / CI #M545-000047-25, Intake #00153979 / CI #M545-000054-25; and Intake #00154671 / CI #M545-000056-25 were related to fall with injury.
- Intake: #00150820 / CI #M545-000044-25was related to multiple aspects of resident care issues.

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

Resident Care and Support Services
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 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

A resident's care plan directed staff to to complete a specific intervention at regular intervals. checks at regular intervals. Two Personal Support Workers (PSWs), and a Registered Nurse (RN) acknowledged the care plan directions did not clearly specify the frequency of the identified intervention.

Sources: Resident's care plan and Interviews with the PSWs and RN

WRITTEN NOTIFICATION: Plan Of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed, and their plan of care was reviewed and revised when the use of an intervention had not been effective.

The use of a specific device was identified as one of the fall prevention interventions in the resident's care plan. Staff indicated that the resident frequently removed and refused the device, and therefore, this intervention had not been effective for the resident.

Sources: Inspector’s observations with resident, progress note, Documentation Survey Report V2, interviews with the PSW and Nurse Manager (NM).

WRITTEN NOTIFICATION: Transferring And Positioning Techniques

NC #003 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 a PSW, and RN used safe transferring and positioning devices when they assisted a resident after a fall. A PSW and a NM acknowledged that after the resident fell, the resident was transferred unsafely without the use of a specific device as per the home's policy.

Sources: Home's CI investigation Notes, Resident's care plan, progress notes, policy titled "Assessment of Resident for Transfer or Lift", and interviews with the PSW and NM.

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the home’s falls prevention and management program when staff did not immediately notify the physician of a significant change in resident #001’s health status after a fall.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, an RN did not comply with the home’s Falls Prevention and Management policy that directed registered nursing staff to notify the physician immediately if a significant change in resident health status was noted after a fall. NM confirmed the

physician should have been notified immediately when RN's assessment indicated there was a significant change to the resident's health status.

Sources: Resident's clinical records; home's policy "Falls Prevention and Management"; and interviews with the RN and NM.

WRITTEN NOTIFICATION: Administration Of Drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Resident's medication was not administered to the resident on an identified date and time, as prescribed by their physician.

Sources: Review of resident's physician orders, medication and treatment administration record, and progress notes; interviews with the RN, NM and Director of Nursing.