



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 8, 2013	2013_219211_0003	T-2165-12	Critical Incident System

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

Long-Term Care Home/Foyer de soins de longue durée

KIPLING ACRES
2233 KIPLING AVENUE, ETOBICOKE, ON, M9W-4L3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 4, 5, 6, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care, Nurse Manager, Registered Nursing Staff, Personal Care Assistants

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed the home's fall prevention policy

The following Inspection Protocols were used during this inspection:



Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

- 1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding. O. Reg. 79/10, s. 107 (1).**
- 2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**
- 3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).**
- 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).**
- 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**
- 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is immediately informed of an unexpected or sudden death.[107.(1)2.]

Resident #001 was found face down on the floor at the front of her/his wheelchair and was sent to the hospital for further assessment. An identified Registered Nurse (RN) was informed by the hospital that resident #001 had passed away. The RN informed the Director of Care of the above. An interview with the Director of Care confirmed that resident #001's unexpected death was not immediately reported to the Director. [s. 107. (1)]



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Loi de 2007 sur les foyers de
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Issued on this 8th day of March, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

A handwritten signature in cursive script, appearing to read "Wallerstein".