Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 26, 2018	2017_493652_0019	025875-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE KENSINGTON HEALTH CENTRE
25 BRUNSWICK AVENUE TORONTO ON M5S 2L9

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

THE KENSINGTON GARDENS
25 BRUNSWICK AVENUE TORONTO ON M5S 2L9

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

NATALIE MOLIN (652), ADAM DICKEY (643), SHIHANA RUMZI (604), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 5, 6, 7,8,11,12,13,14,15,19,20,21,22,27

The following critical incident (CI) inspections were conducted concurrently with the RQI:# 025875-17 CIS #000020-17 (related to plan of care) ; CIS #000027-17; (related to Prevention of Abuse and Neglect); CIS #000005-17 (related to Reporting Certain Matters to Director, Safe and Secure Home).

The following complaint inspections were conducted concurrently with the RQI: Log# 033394-16 (related to Infection Prevention and Control Program, Nursing and Personal Support Services); #033812-16 (related to Duty to Protect);006052-16 (related to plan of care, nutrition care and hydration); #019728 (related to Residents' bill of rights).

The following follow up inspection was conducted concurrently with the RQI:Log #004041-17(related to safe and secure home)

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Resident Care (North building), Director of Resident Care (South), Food Service Worker, chef, food service manager, Dietitian, director of support services, assistant to the Director of Client Services, Resident Team Coordinator, Physiotherapist, registered staff (North building), registered staff, practical care aides; Residents' Council president and Family Council representative,residents, substitute decision makers (SDMs), and complainants.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dignity, Choice and Privacy
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #002	2016_491647_0011	643
O.Reg 79/10 s. 9. (1)	CO #001	2016_491647_0011	643

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A Critical Incident Report(CIR) was submitted to the Ministry of Health (MOHLTC) on an identified date related to plan of care.

Record review of resident # 002’s progress notes on an identified date, revealed the personal care attendant (PCA) reported an impaired skin integrity on resident #002’s body part.The origin of the impaired skin integrity was unfounded.

Record review of resident #002’s written plan of care on an identified date, revealed resident #002 is at risk for a specified impaired skin integrity to his/her body part and staff to be very careful and gentle during transfers and during care. This written plan of care also revealed resident #002 requires two people physical assistance when performing an identified activity of daily living (ADL) related to an identified deficit and physical impairment.

Interview held with staff #118 revealed on an identified date when he/she worked on an identified shift, he/she repositioned resident #002 in a specified location without assistance during care and did not follow the plan as outlined in the resident #002's plan of care.

Interview with the Director of Resident Care revealed resident # 002 did sustain an impaired skin integrity to his/her body part of unknown cause and staff #118 received

disciplinary actions for providing care to resident #002 unassisted and did not follow the resident’s plan of care.

2. The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, because care set out in the plan has not been effective, the licensee considered different approaches in the revision of the plan of care.

The home called the after hours Ministry of Health and Long Term Care (MOHLTC) Action line on an identified date and time, indicating a resident to resident allegation of an abuse. The caller further stated the incident occurred in an identified home area where resident #033 and resident #034 engaged in an identified activity. Both residents have the same identified diagnosis. Substitute Decision-Maker (SDM) for both residents were notified and the police was called. The residents were separated and incident of this kind had not occurred between the two residents. The home also submitted a Critical Incident System (CIS) report, to the MOHLTC on an identified date. The CIS report stated both residents were in an identified location to attend an identified program at a particular time, after the program completed the resident remained in the identified location. At an identified time, the nurse checked on both residents and they were having a conversation and snacks in an identified location at an identified time, a staff member saw resident #033 standing beside resident #034. Resident #033 was rubbing an identified area of resident #34's body and was moving closer to co-resident. The staff intervened and observed resident #033's clothing was open and co-resident was rubbing resident’s identified body part. The staff member separated the residents and informed the team leader. The CIS report further states the home interviewed the two residents and an investigation was carried out and the police was called.

A review of resident #034’s assessment documentation close to the time of the above incident was carried out and a specified quarterly review assessment on an identified date, indicated moderate cognitive impairment.

A review of resident #034’s written plan of care on an identified date, did not consist of any focus related to the inappropriate behaviour identified. The next written plan of care on an identified date, which was carried out post incident consisted of a “Focus” for problematic manner in which resident acts characterized by an identified inappropriate behaviour related to: resident makes inappropriate remarks, resident gestures to other residents &/or staff inappropriately. The interventions are as follows:
- Avoid type of conversation that could encourage or initiate inappropriate behavior.
- Constant supervision in recreation programs

- Determine cause and previous identified history and document it.
- Document a summary of each episode.
- Encourage attendance at recreational/ activation programs.
- Explain and explore with resident effects of his/her behavior on other residents and staff
- Only PCA of an identified gender were to provide care. Only housekeeping of an identified gender to clean the room when resident is inside the room. If a staff of an identified gender (maintenance/housekeeping) need to do something inside the room, need to ensure that resident is out of the room.
- Protect other residents if unable to protect themselves.
- Provide privacy
- Remain calm and avoid angry reactions towards resident
- Remove resident from public area when behavior is disruptive/ unacceptable. Talk with resident in
a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity

A review of the identified electronic documentation on an identified date, for resident #034 carried out by Registered Nurse (RN) #112, stated resident #034 was known for having friendly gestures, rubbing identified body parts of co-residents, had an identified diagnoses and has a past history of an identified offense. Further electronic documentation review indicated the resident had further identified inappropriate behaviours after a specified date, which is as follows:
-On an identified date : Resident was walking in to co residents room on an identified unit wearing only his/her identified garment and indicated to home's staff co resident had asked him/her to come to his/her room.
-On an identified date: Resident came to the nursing station pulled down his/her identified garment, pulled down his/her identified garment and resident #034 exposed him/herself.
-On an identified date: Resident came into an identified location at an identified time and exposed him/herself pulling identified garments exposing him/herself to other residents.
-On an identified date: Resident was found walking along an identified location then stopped in front of an identified area where a co resident was and resident #034 exposing his/her body part raised his/her clothing, and was not wearing an identified garment. The electronic documentation record did not indicate it was a specified recurring behaviour.
-On an identified date: The resident was in the elevator with a staff member, with three other resident. When the resident was being brought out of the elevator by the staff member the resident motioned his/her hand as if he/she was hitting a resident on his/her

bum.

An interview with resident #034 was carried out and the resident indicated he/she was unaware of the above incident.

An interview with resident #033 was carried out and he/she was able to recall and incident where he/she participated in an identified activity with another resident in his/her room. Resident #033 indicated he/she was unable to remember who the other resident was and stated both parties consented the identified activity in his/her room. The resident was informed of the above incident and he/she stated he/she can't recall the incident.

An interview was carried out with RN #112 who stated it was the homes expectation that the written plan of care be revised quarterly, with any significant changes, and at any time when the interventions are not effective. The RN and the inspector reviewed resident #034's plans of care on two identified dates, pre and post alleged behaviours identified and the RN indicated the resident continued to have inappropriate behaviours after an identified date. The RN acknowledged that the interventions are identical on both plans of care and no new interventions where carried out since an identified date, when the residents identified behaviours continued.

An interview was conducted with the Director of Resident Care (DOC) #100 who stated that it was the home's expectation that the written plan of care is to be updated with any changes, quarterly and any time throughout when interventions need to be changed. The DOC and Inspector reviewed resident #034's written plans of care on two identified dates, the DOC acknowledged that the two plan of care interventions where not revised as they are the same but resident #034 continued to present with an identified inappropriate behaviours. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for the resident is provided to the resident as specified in the plan and to also ensure that residents are being reassessed and the plan of care revised because care set out in the plan is not effective and different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that foods were served at a temperature that is both safe and palatable to the residents.

The Ministry of Health and Long-Term Care received a complaint related to food quality and temperature of food served when residents receive tray service in their room.

In an interview, resident #040 stated that the food is often served cold as he/she is the last one to be served because he/she does not go to the dining room for meals.

Observations conducted by the inspector on December 15, 2017, revealed Food Service Worker (FSW) #104 measuring and recording temperatures of food products prior to service at the lunch meal. Upon observation FSW #104 used a probe thermometer to measure the temperature of a half pan of macaroni and cheese at approximately 1206 hours. The inspector observed the temperature of the probe thermometer to read approximately 130 degrees Fahrenheit (F).

In an interview, resident #043 stated that the macaroni and cheese was luke warm and could be hotter. Resident #044 stated that the macaroni and cheese was warm enough, though was bland.

Review of the HACCP Servery weekly food temperature and waste log located in the unit servery revealed the temperature for hot entrée #1 was recorded by FSW #104 to be 136 degrees F. The FSW then entered a second temperature reading of 144 degrees F for entrée #1. The log indicated that Serving temperature for hot foods is minimum of 140 degrees F, and that food is to be returned to the kitchen of the food is not at the right temperature.

In an interview, FSW #104 stated that the pan of macaroni and cheese was 136 degrees F, so he/she proceeded to cover the pan and leave it in the steam table to heat. FSW #104 stated that the process would be to cover a food that was not at 140 degrees F prior to serving until it reached 140 degrees. FSW #104 further stated that if the food product was not close to 140 degrees F it would need to be sent back to the kitchen to be reheated to 165 degrees F.

In an interview Food Service Manager (FSM) #106 stated that it was the expectation of the home that if a hot food product was below 140 degrees F then it should be reheated by placing it into the steam table to bring back to temperature. The FSM stated that the food product should be heated in order to reach the internal temperature of 140 degrees F. Inspector requested FSM to retrieve the policy related to food temperature procedures and the FSM stated the policy instructed staff to bring the food product back to the kitchen to be reheated quickly and should be reheated to at least 165 degrees F.

In an interview, chef #108 stated that the macaroni and cheese was baked just prior to placing it in the holding box for transfer to the units. Chef #108 stated that the pans of macaroni and cheese were not covered prior to placing them in the hot box to send to the units.

Review of the home’s policy titled “Re-heating Food” policy number M5-690 revealed that foods need to be reheated to preserve product safety and quality. The policy further indicated a food product must be heated in a proper cooking method, not in a steam table or bain-marie and reheating of food must be done quickly to 165 degrees F for 15 seconds.

In an interview, the Director of Support Services (DSS) stated that food temperatures are taken once in the kitchen prior to transport to the units and again when placed in the steam table prior to service. The DSS further stated it was the expectation of the home for hot food products that were not at least 140 degrees F prior to service to be brought back to the kitchen to be reheated to at least 165 degrees F. The DSS acknowledged that the FSW did not follow the home’s protocol for reheating foods and that the food was not served at a temperature that was safe and palatable to the residents. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that foods were served at a temperature that is both safe and palatable to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored were kept locked at all times, when not in use.

On December 14, 2017, at 0825 hours (hrs), the inspector was conducting observations for resident #032, in the South building first floor West home area when the inspector observed an unlocked medication cart to be parked outside the dining room across from the nursing station. The inspector observed residents going into the dining room for the breakfast meal and no nursing staff in the area. The inspector was able to open the drawers in the medication cart and had access to the resident's medications. The inspector remained with the medication cart and shortly after RPN #119 arrived from the dining room.

An interview was conducted with RPN #119 who stated it was the home's expectation that the medication cart be locked when not in use or being observed. The RPN acknowledged that he/she did not lock the medication cart and stated it was a risk to leave the medication cart unlocked as residents had access to the medication.

An interview was carried out with the home’s Resident Team Coordinator (RTC) #113 for the South building who indicated it was the home's expectation that the medication carts be locked when it is not in use by the nurses. The RTC stated by leaving the medication cart unlocked residents or anyone passing in the home would have access to the medication stored in the cart and stated it was unacceptable practice. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #4: 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 fire, unplanned evacuation or intake of evacuees. 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 has failed to ensure that the Director was immediately informed of a missing resident who returned to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

Critical incident System report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date. Review of the CIR revealed that resident #042 was noted to be missing by staff at an identified date and time, and had returned to the home with slight injury to his/her body parts. Further review of the CIR revealed that the MOHLTC after hours pager was not contacted about this critical incident.

Review of resident #042's progress notes revealed he/she was noted by PCA #114 to be missing from the unit at an identified date and time. Resident #042 was noted to have been wandering the unit prior. Code Yellow was initiated and North and South buildings was searched for resident #042. Resident #042 was returned to the home via ambulance with police at an identified time. Resident #042's progress notes further revealed that an injury were found on the resident identified body parts on an identified date and time. It was noted in resident #042's progress notes that an injury was found to his/her identified body parts.

In an interview, Director of Resident Care (DORC) #100 stated that it was the expectation of the home to report a missing resident who has been missing for greater than three hours or has returned to the home with significant injury immediately to the Director. DORC #100 stated he/she was not aware that a resident who was missing from the home for any duration and returns with any injury must be reported to the Director immediately. DORC #100 further stated that he/she did not call the MOHLTC after-hours line as the injury was minor to resident #042 and was not missing for greater than three hours. DORC #100 acknowledged that the licensee had failed to ensure that the Director was immediately informed of a missing resident who returned to the home with an injury regardless of the length of time the resident was missing. [s. 107. (1)]

Issued on this 8th day of February, 2018

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

Original report signed by the inspector.