Ontario

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
Apr 13, 2018	2018_370649_0003	005097-16, 031963-16, 032722-16, 010593-17, 018505-17	Complaint

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

JULIEANN HING (649), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 31, February 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 23, 26, 27, 28, and April 6, 2018.

Log #032722-16 and #031963-16 related to residents' bill of rights
Log #005097-16 related to duty to protect and altercations
Log #018505-17 related to falls prevention and management, pain management, accommodation services and reporting
Log #010593-17 related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with the Directors of Resident Care (DRCs), Resident Team Coordinators (RTCs), Nurse Managers (NMs), Physician, Registered Nurses (RNs), Physiotherapist (PT), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), Staffing Coordinators, Supervisor of Health and Safety, Behaviour Support Outreach Team (BSOT), Residents and Family members.

During the course of the inspection, the inspector observed staff to resident interactions, observed the resident home areas, conducted interviews, reviewed relevant policies, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Ministry of Health and Long-term Care (MOHLTC) received a complaint that the home did not identify resident #008 at risk for falls and was concerned about the resident falls.

Interview with the complainant revealed that due to lack of care at the home, resident #008 had many falls in the home and each fall resulted in a massive change in the resident's health status.

A review of resident #008's written plan of care revealed that the resident was at high risk for falls and staff to establish toileting routine for the resident.

A review of progress notes revealed that the resident fell in an identified area of the home. The resident decided to go to the washroom without using a walker. Resident lost balance in the washroom and fell on the floor. The nurse was close by and arrived to help the resident, no injury noted upon assessment.

A review of progress note revealed that the fall occurred in July 2016, and a new intervention to establish toileting routine for the resident was developed.

A review of the resident's clinical records revealed that the toileting routine was not established for the resident.

A review of resident #008's progress notes revealed the resident had a fall in an identified area of the home. The resident decided to go to an area of the home without their mobility aid, lost their balance and fell on the floor no injury noted upon the assessment.

A review of resident #008's progress notes revealed the resident had some falls related to resident refusing to call for help.

Interview with Personal Care Aide (PCA) #133 revealed that the written plan of care indicating to establish toileting routine for the resident to prevent falls does not direct staff about what time the resident was to be toileted and it does not give clear direction to staff.

Interviews with Registered Practical Nurse (RPN) #134 and #135 revealed that there should be a specific toileting routine developed for the resident to prevent the resident from falls.

Interviews with Resident Team Coordinator (RTC) #123 and Director of Resident Care (DRC) #126 revealed that there should be clear direction for staff to toilet the resident to prevent the resident from further falls. The home has a procedure to initiate three days voiding diary for the resident and based on that toileting routine should be established for the resident. To establish toileting routine for the resident to prevent falls is not clear intervention for staff to understand and follow the routine for the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and are consistent with and complement each other.

MOHLTC received a complaint that the home did not identify resident #008 as having an identified medical condition.

Interview with the complainant revealed that resident #008 had an identified medical condition and indicated that the staff could have easily identified the medical condition and initiated treatment. The complainant had reported to staff about the resident's medical condition.

A review of progress notes revealed that the resident was identified with a symptom and encouraged to consume more fluids in December 2016.

A review of progress notes revealed that lab work was requested by the family for an upcoming appointment for the resident.

A review of the progress notes revealed that the resident was identified with the symptom again 12 days later.

Abnormal lab results were obtained and the doctor was notified and ordered to send the resident to the hospital for further assessment. In the hospital, the resident was diagnosed with a medical condition and treated with medication.

Interview with PCA #133 revealed that if they notice the identified symptom they need to report it to the registered staff.

Interview with RPN #134 and #135 revealed that they need to call the doctor and communicate about the resident symptom to get further direction.

Interview with RTC #123 and DRC #126 revealed that any time when staff notice the identified symptom they need to inform the doctor to receive further direction.

The licensee failed to collaborate in the assessment of the resident when the resident was identified with a symptom and the home failed to call the physician to get further direction. [s. 6. (4) (a)]

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 there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 16th day of April, 2018

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

Original report signed by the inspector.