Ontario

**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 prévue 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 Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 30, 2019 | 2019_616722_0016 | 008086-19, 009052-19 | Critical Incident System |

## 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

COREY GREEN (722)

## 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): July 16, 17, 18, 19, 22, 23, and 24, 2019**

**During this inspection, the following intakes were inspected:**

**Log #009052-19 - Follow-up inspection for Compliance Order #001 from inspection #2019_634513_0006 related to falls.**
**Log #008086-19 related to falls.**

**This Critical Incident System inspection was conducted concurrently with Complaint inspection 2019_616722_0015.**

**During the course of the inspection, the inspector(s) spoke with residents, personal care aides (PCAs), registered practical nurses (RPNs), and the Director of Care (DOC).**

**The inspector made observations of residents and resident home areas, reviewed resident health records (electronic and hard copy), and reviewed relevant policies and procedures.**

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

**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)**

**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. 6. (7) | CO #001 | 2019_634513_0006 | 722 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where the Regulations required the licensee of a long-term care home to have, institute or otherwise put in place a strategy, that the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48. (1) 1., and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to have a falls prevention program that provided strategies to reduce or mitigate falls, that included the monitoring of residents.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management Program" policy (#M2-570, dated March 2004, revised July 2018), which provided the following strategies for monitoring residents in relation to falls:
- Fall Prevention: Registered Nursing Staff: Collaborate with the resident/substitute decision maker (SDM), family and interdisciplinary team to conduct the Falls Risk Assessment in PointClickCare (PCC) within 24 hours of admission, quarterly, and when there is a significant change in health status.
- Fall and Post Fall Assessment and Management: Registered Nursing Staff: Initiate the Head Injury Routine (HIR) for all unwitnessed falls, and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy; the HIR is done every 15 minutes for an hour for signs of neurological changes (e.g., facial droop, behaviour changes, and weakness on one side), every 30 minutes for two hours, hourly for four hours, and every four hours for 48 hours, unless ordered otherwise.

A critical incident report (CIS #2852-000018-19) was received by the Director that described two recent unwitnessed falls that involved resident #003. One fall occurred on on an identified date, where the resident was transferred to hospital that following day and was diagnosed with specified injuries. A second fall occurred on a later specified date, where the resident was transferred to hospital two days later, and died several days later due to injuries sustained during the fall.

Inspector #722 reviewed the progress notes for resident #003, from admission until the resident was transferred to hospital on a specified date, which indicated that the resident sustained seven falls. The post fall assessments documented in the progress notes indicated that resident #003 either sustained no injury, or only minor injuries, for most of the falls. The progress notes indicated that after two of the falls, the resident was sent to the hospital and was diagnosed with specified injuries; however, there was no evidence that one of the injuries was caused by the fall. On another specified date, resident #003 was transferred to hospital two days after a fall; the progress notes indicated that the resident was diagnosed with multiple serious injuries, transferred to a trauma centre, and died several days later as a result of those injuries.

Inspector #722 reviewed the assessments for resident #003, and identified a Falls Risk Assessment completed when resident #003 was admitted to the home, which indicated that the resident was at a specified risk for falls. There were no other Falls Risk Assessments identified in the resident's health chart, and there were no further Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessments identified that determined the resident's risk for falls.

Inspector #722 interviewed DOC #103, who indicated that the expectation was that, as per the Falls Prevention and Management Program policy, the Falls Risk Assessment was to be completed in the electronic health chart, PointClickCare (PCC), to assess residents for their risk of falls on admission, quarterly, and with a significant change in the resident's condition. The DOC acknowledged that the resident's risk for falls had changed since admission, and was not accurate. The DOC indicated that the resident had significant changes in their health status on several occasions, and the Falls Risk Assessment should have been updated to reflect the resident's risk for falls.

The progress notes indicated, for identified dates, that the head injury routine (HIR) was initiated after six of resident #003's seven falls. There was no indication in the progress notes on one specified date that the HIR was initiated; however, progress notes on other specified dates indicated that the HIR was ongoing.

Inspector #722 reviewed the HIR forms in resident #003's health chart, for each of the falls identified above, which had spaces available for 24 entries: every 15 minutes for one hour, every 30 minutes for two hours, every one hour for four hours, and every four hours for 12 hours. Each time slot had space available for vital signs (temperature, pulse, respiratory rate, and blood pressure), left and right pupil size and reaction, level of consciousness, and bilateral grip strength. These time slots and assessment items were consistent with the home's policy related to the HIR as detailed above.

Review of the HIR for each of the falls detailed above indicated that the required assessment items for each of the 24 required entries were incomplete, in part or in full, for the following falls that occurred on specified dates: fall #1 (18 entries blank/incomplete), fall #2 (no HIR form was located), fall #3 (14 entries blank/incomplete), fall #4 (14 entries blank/incomplete), fall #5 (11 entries blank/incomplete), fall #6 (15 entries blank/incomplete), and fall #7 (14 entries blank/incomplete), 2019. In some instances, the time period indicated that the resident was sleeping, eating, or refused the assessment.

Inspector #722 interviewed DOC #103, who explained that the expectation was that the HIR form should have been initiated and completed as per the policy for all of resident #003's falls, since most of the falls were unwitnessed, and the resident received a specified medication. The DOC also acknowledged that while the resident may refuse the assessment, none of the assessment times should have been left incomplete due to resident sleeping or eating.

The licensee failed to comply with strategies to monitor a resident at risk of falls, as identified in their Falls Prevention and Management Program policy, when staff did not update resident #003's Falls Risk Assessment when the resident's health status changed, and the HIR assessments for resident #003 were routinely not completed as per the licensee's policy after almost every fall. [s. 8. (1) (a),s. 8. (1) (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 strategies described in the falls prevention program policy, specifically related to completion of falls risk assessments and the head injury routine, are complied with,, to be implemented voluntarily.***

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**Issued on this 30th day of July, 2019**

[redacted]

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

**Original report signed by the inspector.**