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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: December 20, 2023
Inspection Number: 2023-1337-0007
Inspection Type: Complaint Critical Incident
Licensee: The Kensington Health Centre
Long Term Care Home and City: The Kensington Gardens, Toronto

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2024.01.05 14:54:25 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 15, 16, 17, 21, 22, 28, 2023
The inspection occurred offsite on the following date(s): November 23, 24, 29, 2023

The following intake(s) were inspected:
- Intake: #00097563 - Critical Incident System (CIS) #2852-000031-23) related to Outbreak Management
- Intake: #00099774 - Complaint related to medication administration, continence care, pest control, nutrition and hydration, skin and wound, palliative care

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Palliative Care

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 (5)
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to weight and skin and wound changes.

Rationale and Summary

The care plan indicated the involvement of the SDM.

i) Review of resident #001's weights indicated that there were changes to the resident's weight over a two month period. A review of progress notes did not identify that the SDM was notified of the change in weight.

The home's weight management policy indicated that staff were to discuss the resident's weight change and possible interventions with the resident or the resident's SDM and document the discussion and outcome.

Registered Practical Nurse (RPN) #107, Registered Dietitian (RD) and the Director of Care (DOC) acknowledged that the resident's SDM was not made aware when there was a change to the resident's body weight.

Failure to discuss weight changes with the resident's SDM did not allow the SDM the opportunity to participate fully in the development of the plan of care

Sources: Resident's progress notes; interviews with the SDM, RD, RPN #107, DOC and other staff.

ii) Registered Nurse (RN) #112 documented in the progress notes resident #001's wound was not improving and requested Wound Care Lead Nurse #102 to assess. The resident was assessed by the Wound Care Lead and new orders for wound care development and implementation of the care plan.

The DOC acknowledged that the staff were to notify the resident's SDM when there was new orders for the wound and for any changes related to the wound. were

written. A review of the progress notes did not identify that the SDM was notified of the initial changes to the wound.

The home's Skin and Wound policy indicated that upon discovery of an altered skin integrity, communicate findings and recommendations to resident or SDM and provide an opportunity to the resident and SDM to participate fully in the

The DOC and the Wound Care Lead #102, both acknowledged that the resident's SDM was not immediately made aware of the change to the resident's wound and the SDM was not given the opportunity to participate fully in the resident's nutrition and skin and wound care.

Failure to notify the resident's SDM when there was changes to the wound, did not allow the SDM an opportunity to participate in the implementation of the plan of care related to wound care management.

Sources: Resident's progress notes; interviews with the SDM, Wound Care Lead #102, DOC and other staff

[189]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Rationale and Summary

Resident #001 was admitted with an identified medical condition and a care plan was put in place to manage the condition with a medical device. The care plan directed the nurses to check the identified device before and after meals and to empty as needed.

On an identified date, during the meal service while a family member was visiting, an accident occurred with the resident's device. RN #110 documented that they informed the family they planned to change the device after the meal service.

The DOC acknowledged that the device should have been checked prior to meals and the care plan was not followed.

Staff's failure to follow resident #001's plan of care related to device care put them at risk of device leakage and possible skin impairments.

Sources: review of resident #001's progress notes, care plan, interview with RN #110, DOC and other staff.

[189]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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, (b) the resident's care needs change or care set out in the plan is no longer necessary

The licensee has failed to ensure that resident #001's plan of care was revised when the care set out in the plan of care for fall prevention was no longer necessary.

Rationale and Summary

Resident #001's plan of care indicated that they required a fall prevention intervention. On an identified date, the fall prevention intervention was documented to be missing after the resident room was cleaned. Additional documentation noted that the fall prevention intervention was not in place.

RN #112 acknowledged that the fall prevention intervention was not in place and stated that it was was missing after the cleaning. RN #112 reported that the resident was not at risk for falls as the time of the cleaning, and the fall prevention intervention was not required for the resident. RN #112 acknowledged that the care plan was not updated.

Failure to revise the care plan placed the resident at risk of staff not being aware that falls interventions had changed for resident #001.

Sources: review of resident #001's progress notes, plan of care, interview with RN #112.

[189]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to resident #001 under the skin and wound care program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary

Resident #001's was identified with an area of altered skin integrity. The weekly skin and wound assessments were not completed in their entirety. Pertinent information such as the measurement of the wound (length and depth) and the classification of the wound were not routinely included in the weekly assessment. On identified dates, it was documented that the resident's wound was deteriorating, however no measurement of the change was recorded.

RPN #107 and the DOC both acknowledged that the weekly skin assessments were not completed as required. The DOC stated that staff needed to complete the skin and wound assessment in their entirety as per policy.

Failure to complete documentation for weekly skin and wound assessment for resident #001 increased the risk of changes in the wound not being identified and addressed in a timely manner.

Sources: Review of resident #001's progress notes, weekly skin assessments, interview with RPN #107, DOC and others.

[189]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that, a resident exhibiting altered skin integrity, received immediate treatment and interventions to promote healing, and prevent infection.

Rationale and Summary

Resident #001 was admitted to the home with a wound which healed and then re-opened. On an identified date, it was documented that two areas on the wound were not healing and picture of the wound was sent to Wound Care Lead #102 and Nurse Practitioner #115. Wound Care Lead #102 assessed the wound virtually, and an order for wound care was written.

On an identified date, RN #112 documented that the wound was not improving and an email was sent to Wound Care Lead #102.

On an identified date RN #119 documented that the wound condition had worsen and questioned if the wound advanced to another stage. RN #119 documented that the Nurse Manager was informed.

RN #112 discussed the wound at their wound care rounds and another emailed was sent to Wound Care Lead #102 about the wound. Wound Care Lead #102 assessed the wound and new orders were written for daily wound care.

During the weekly skin assessment on identified dates, it was documented that the wound was deteriorating.

On an identified date, RN #112 documented that the wound was not healing. Daily dressing continued to be applied with some improvement, but on a subsequent assessment, the Nurse Practitioner identified that the wound had worsen.

RN #112 reported that they had concerns with the wound and emailed Wound Care Lead #102. RN #112 reported that they felt the wound care treatment that was applied was not effective for the wound, until the Nurse Practitioner became involved.

Nurse Practitioner #115 stated that they received an email from the nurses stating that the wound was not getting better, and they received another email that the wound was deteriorating. The Nurse Practitioner stated that when they received the initial email, the nurses did not inform them of the classification stage of the wound.

Wound Care Lead #102 acknowledged that they did not immediately assess the wound when the nurses reported the wound was deteriorating.

The DOC acknowledged that the wound for resident #001 was not immediately assessed by Wound Care Lead #102 when deterioration of the wound was identified. The DOC stated that a skin and wound assessment should have been completed immediately after reported by the nurses and treated.

Failure to immediately assess and treat resident #001's wound increased the risk of changes in the wound not being addressed in a timely manner.

Sources: Review of resident #001's progress notes, skin and wound assessment, interview with RN #112, Wound care Lead #102, Nurse Practitioner #115, DOC and other staff.

[189]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter

The licensee has failed to comply with the system to measure and record resident #001's weight.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a weight monitoring system to measure and record each residents' weight on admission and monthly thereafter and must be complied with.

Specifically, staff did not comply with the policy for Weight Monitoring, which stated residents are weighed during the first week of every month and entered into Point Click Care (PCC) by the seventh of the month and for weight variance of 2kg, residents are to be reweighed by the 10th of the month.

Rationale and Summary

A complaint was received by the Director with concerns of weight changes for resident #001.

Review of resident #001's weights indicated that on an identified month, the weight was recorded showed a significant change in body weight. The RD assessed the resident and requested the resident to be reweighed, however the resident was not reweighed until one week later.

RPN #107 stated that residents' weights were taken by the seventh of the month and if the resident required to be reweighed, the weight was taken immediately. RPN #107 acknowledged that the resident was not reweighed as per policy.

The DOC acknowledged that the weight monitoring was not completed as per policy, and that the resident should have had their weight taken by the seventh of the month and the reweighed obtained within one week of RD request.

Failure to take the weight as required placed the resident at nutritional risk when the weight was not obtained.

Sources: Weight monitoring record, policy titled "Weight Monitoring" M2-1140, last revised September 2014, interview with RPN #107, RD, DOC and other staff

[189]

WRITTEN NOTIFICATION: WEIGHT CHANGES

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.

s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month

The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, where there is a change of 5 per cent or more of body weight over one month.

Rationale and Summary:

On an identified month, resident #001 had recorded weight documented. The following month, the recorded weight showed a change of 5 per cent over a one month period. The resident was not reweighed and a referral was not sent to the RD. There was no documented actions taken as a result of the weight change.

RPN #107 and the DOC stated that residents were to be reweighed when there was a weight variance of 2 kg, and a nutrition referral should have been sent to the dietitian to assess so that the nutrition risk status could have been addressed. The DOC acknowledged it was not completed.

Failure to monitor weight changes and implement interventions placed the resident at nutritional risk.

Sources: Weight monitoring record, policy titiled “Weight Monitoring” M2-1140, last revised September 2014, interview with RPN #107, RD, DOC and other staff.

[189]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented. Specifically, Section 9.1 (b) "the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program", including the four moments of hand hygiene.

Rationale and Summary

During a meal observation, PSW #105 assisted with serving beverages to residents. A resident started to cough, and the PSW touched the resident on their back to assist the resident with coughing. PSW #105 then went to the kitchen servery and received meal plates, served two residents and continued to assist with meal service without performing hand hygiene.

The home's policy titled "Hand Hygiene" directed all staff to clean their hands before/after touching the resident or any object or furniture in the resident's environment.

PSW #105 acknowledged that they did not perform hand hygiene after touching the resident and before serving meals to other residents.

IPAC Lead #103 acknowledged that staff were to perform hand hygiene before and after coming into contact with a resident or resident's environment.

Failure to perform hand hygiene after initial resident contact increased the risk of transmission of infection.

Sources: Observation of meal service, review of policy Hand Hygiene M6-100 last revised March 2020, IPAC Standard for LTCH's last revised September 2023, interviews with PSW #105 and IPAC Lead #103.

[189]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored.
IPAC Standard for Long-Term Care Homes (revised September 2023), s. 3.1 (b) states the licensee shall ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

i) The home was in outbreak during an identified time period. The home required staff to monitor symptoms indicating the presence of infection every shift on the unit for the affected residents.

The public health line listing identified the onset of first symptoms for resident #005 was on an identified date, and the resident were placed on additional precautions accordingly. Record review of the resident's progress notes showed that symptoms indicating the presence of infections were not documented every shift.

ii) During the inspection period the home was in outbreak.
The public health line listing identified the onset of first symptoms for resident #002 was on an identified date, and for resident #003 on a different identified date. Both residents were placed on additional precautions accordingly.

Record review of the residents' progress notes showed that symptoms indicating the presence of infection were not documented every shift.

RPN #109 and IPAC Lead #103 both indicated that symptoms indicating the presence of infection should have been monitored every shift and documented in the residents' progress notes. IPAC Lead #103 acknowledged that there were missing monitoring documentation for identified residents.

There was moderate risk when the home did not document symptoms indicating the presence of infection every shift.

Sources: Review of resident #002, #003, #005's progress notes, review of the public health line listing; interview with RPN #109 and IPAC Lead #103.

[189]

WRITTEN NOTIFICATION: REPORTING OF CRITICAL INCIDENTS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary

A critical incident report was submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent out on August 18, 2023 indicated that for critical incidents reported immediately outside of business hours, to call the Service Ontario After-Hours Line.

Infection Prevention and Control (IPAC) Lead #103 confirmed that the home submitted a critical incident report but did not call the Service Ontario After-Hours Line.

Sources: Critical Incident Report 2852-000031-23; MLTC Reporting Requirements - reference sheet; and interview with IPAC Lead #103.

[189]