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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2014	2014_321501_0008	T-715-14	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

SUSAN SEMEREDY (501), TILDA HUI (512)

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): June 11 and 12, 2014.

During the course of the inspection, the inspector(s) spoke with support services general manager, registered staff, registered dietitians (RDs), director of resident care, resident team coordinator, social worker, safety and wellness coordinator.

During the course of the inspection, the inspector(s) observations and reviewed resident and home records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Nutrition and Hydration
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed 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.

Record review revealed that resident #1 slid out of bed on an identified date, and a Fall Risk Screening Tool was completed by registered staff. Review of a progress note on an identified date, revealed that bed handles for the foot of resident #1's bed were not working. Review of maintenance records revealed that three requests were made on May 25 and 26, 2014, indicating that the foot of resident #1's bed was not working and needed immediate attention because the resident was sliding out of bed two days ago. Interview with the support services general manager revealed that the handles for the foot of the bed were never broken but maintenance staff had on three occasions provided training to staff on the proper technique to raise and lower the foot of the bed.

Review of the Fall Risk Screening Tool completed on an identified date and the a progress note of a follow up meeting on an identified date, did not indicate how or why the resident fell out of bed and did not take into consideration the problem with the foot of the bed. Staff interviews confirmed that the team's assessment of the fall did not include collaboration with those who witnessed the fall and did not take into consideration all possible explanations for the fall. [s. 6. (4) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.
Record review revealed that resident #1 slid out of bed on an identified date, and a Fall Risk Screening Tool was completed by registered staff. Review of this screening tool and a progress note of a follow up meeting on an identified date revealed that one of the interventions recommended was to lower the bed. On an identified date, the inspector observed that the bed was at a normal bed height. Record review and staff interviews confirmed that lowering of the bed had not been communicated to staff providing direct care. [s. 6. (4) (b)]

3. The licensee failed to ensure that the provision of the care set out in the plan of care is documented.

The home's policy #M2-500 titled Enteral Feeding Procedures revised April 2008, in the Resident Care Manual states that the time, rate and amount of the feed is to be documented on the Enteral Feeding Daily Intake Record.

Record review revealed that resident #1 is to receive enteral feed daily with manual and automatic water flushes. Review of the Enteral Feeding Daily Intake Record reveals that for the months of March, April and June 2014, there were 28 days with incomplete documentation. Interviews with the registered staff and RD confirmed that this documentation was incomplete which makes it difficult to estimate daily nutritional intake and assess accordingly. [s. 6. (9) 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 the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident and 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 and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 16th day of June, 2014

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