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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 4, 2015	2015_303563_0018	008695-15	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

KENSINGTON VILLAGE
1340 HURON STREET LONDON ON N5V 3R3

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

MELANIE NORTHEY (563), INA REYNOLDS (524), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 25 - 29, and June 1 - 2, 2015

The following Follow-up Inspection was conducted concurrently during this inspection:
Log # 008379-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian, the Environmental Service Manager, the Director of Food Services, a Maintenance staff member, the Family Council Representative, two Registered Nurses, two Registered Practical Nurses, one Dietary Aide, twelve Personal Support Workers, three Family members and forty Residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **7 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
O.Reg 79/10 s. 221. (1)	CO #002	2015_229213_0007	563
LTCHA, 2007 S.O. 2007, c.8 s. 85. (3)	CO #001	2015_229213_0007	563

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).

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).

Findings/Faits saillants :

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

Observation of Resident # 21, # 33, # 35 and # 45's room revealed the use of side rails. Record review of the current care plan and kardex revealed there were no interventions in place for the use of side rails. Record review of the Minimum Data Set (MDS) Assessment revealed an inconsistency in documentation where by the use of side rails was indicated for bed mobility, but in another section of the MDS it was documented that side rails were not used.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator confirmed interventions related to the use of side rails should be in the care plan to direct front line staff. The RAI-C confirmed care interventions related to the use of side rails would be documented under the "Bed Mobility" focus in the care plan and confirmed interventions are not documented anywhere else except the care plan, and if side rail interventions are not documented in the care plan then staff do not have clear direction for their use.

Staff interview with a Personal Support Worker (PSW) confirmed that the use of side rails is not documented in the kardex and confirmed there are no clear directions to staff as to the purpose of the rails, number of rails and when they are used. The PSW confirmed it is the expectation that the kardex provides clear direction to staff for the use of rails. [s. 6. (1) (c)]

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

Record review of the most recent "Registered Dietitian Note" regarding weight loss for Resident # 45 indicates that there is a physician order for the use of an assistive device at meals. Review of the physicians orders indicate the order was discontinued on September 4, 2014.

Interview with two Personal Support Workers revealed that the resident does not use an assistive device at meals.

The Administrator confirmed that the expectation is that staff and others collaborate with each other so that assessments are integrated, consistent and complement one another. [s. 6. (4) (a)]

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

Record review of the current care plan under the nutrition status focus on PointClickCare (PCC) for Resident # 9 and # 30 revealed that assistive devices are required for the residents to safely consume fluids.

Observation of the breakfast and lunch meal service in the main dining room revealed that the residents were not provided with this assistive device. This was confirmed by a Dietary Aide and a Personal Support Worker.

The Director of Food Services indicated that assistive devices are listed on the residents' diet kardex and confirmed that it is the home's expectation that staff follow the kardex to ensure that each resident is provided with the care as set out in their nutritional plan of care. [s. 6. (7)]

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 is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that staff and others involved in the care of the residents collaborate with each other in the assessment of the resident so that assessments are integrated, consistent and complement one another, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Record review of the "Fall Prevention and Management Program NS-II-265" Policy indicated that a Fall Assessment will be completed quarterly if the "Fall" Resident Assessment Protocol (RAP) is triggered (as a secondary assessment). The home's policy also indicated that after a fall, there will be documentation every shift for 72 hours (post fall).

Review of the MDS assessments for Resident # 41 indicated that the Falls RAP was triggered for each of the three identified assessments. Record review also revealed that a Falls Risk Assessment had not been completed and the clinical record revealed multiple falls occurred this year.

Review of the MDS assessments for Resident # 52 indicated that the Falls RAP was triggered for each of the three identified assessments. Record review also revealed a Falls Risk Assessment had not been completed and there was no documentation completed for 72 hours post fall.

Review of the progress notes did not include consistent documentation for 72 hours after each fall, and only occurred when a Head Injury Routine was initiated. The Administrator verified that Falls Risk Assessments were not completed quarterly and that there was not consistent documentation for 72 hours after each fall and confirms that it is the expectation that the home's policy be complied with. [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 Fall Prevention and Management Program Policy instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Observation of 40 resident bed systems during stage 1 of the Resident Quality Inspection revealed 97.5% of beds had one or more side rails in use.

Record review of the bed entrapment audit completed on February 29, 2012 revealed multiple beds with one or more failed zones for entrapment. The audit identified that reasons for failure were related to the type of side rail in use and rail caps and deck corners were needed for multiple beds. 18 Echo bed types with square corners required rail caps and 105 beds required two or more deck corners to secure the mattress.

Staff interview with the Maintenance staff member and the Environmental Service Manager (ESM) revealed corrective action was taken for all beds with full rails. These rails were equipped with corner guards until the new assist rails were applied and the full rails could then be removed. The ESM confirmed there was no follow up documentation of an entrapment inspection for those beds with the new rail caps and deck corners applied and again when the full rails were replaced with the new assist rails.

The ESM confirmed a follow up bed entrapment audit should have been completed for all bed systems where correction action was taken.

Record review of multiple resident charts in PointClickCare revealed the "Bed Use Risk Assessment 2014 (SVCH)" was not completed. Staff interview with the Administrator confirmed the home does have a bed rail risk assessment tool created, but that no resident who uses bed rails has had a bed rail risk assessment completed. [s. 15. (1) (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 where bed rails are used, the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

Observations during the initial tour of the home revealed the resident-staff communication and response system was absent in the main dining room.

Staff interview with the Environmental Service Manager revealed call bell audits do not include those call bells located in common areas used by residents and confirmed those call bells should also be checked quarterly and confirmed there was not a resident-staff communication and response system located in the main dining room area and a call bell should be available in every area accessible by residents. [s. 17. (1) (e)]

2. The licensee has failed to ensure that the resident-staff communication and response system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Observations of the resident-staff communication and response system revealed all bed side call bells did not use sound to alert staff in 13 resident rooms affecting 26 residents.

Record review of the "Nurse Call System Policy # XVII-D-210.00" dated September 2005 revealed "The nurse call system will be checked quarterly to ensure proper operation for the safety of all residents, staff and family." The policy stated, "Quarterly, the Director of Environmental Services / Maintenance Manager or designate will inspect master control station lights for proper operation and check audio signal for proper operation."

Staff interview with the Administrator confirmed there are two call bell systems in place and one system does not alarm the staff by sound for those 26 residents residing in the East Wing and confirmed the call bell system should use sound to alert staff. The home followed up immediately to activate the sound alarm to alert staff in the East Wing and installed a call bell in the main dining room. [s. 17. (1) (g)]

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 resident-staff communication and response system is available in every area accessible by residents and that the resident-staff communication and response system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the Resident Council meeting minutes revealed multiple complaints and/or concerns related to dining service, food preferences, wandering residents, visitors using resident washrooms and other issues related to services and care.

Interview with a resident revealed the home does not respond in writing within 10 days of receiving complaints from Resident Council. The resident shared multiple complaints were brought forward about food quality and confirmed she did not know what the resolution was.

Staff interview with the Administrator confirmed the home does not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

Review of clinical records revealed Resident's # 1, 10, 21, 29, 41, 48 and 49 have all available medical directives ordered by the physician and available for use including diagnosis specific medications. These residents did not have a supporting diagnosis for the use of these medical directives.

Review of the resident clinical records revealed Resident's # 28, 30, 32, 34, 43 and 49 did not have signed medical directives for the use of specific medical directives and the medical directives were present on the electronic Medication Administration Record (eMAR) for use.

The Administrator confirmed that it is the expectation that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. [s. 117. (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 no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observation during the initial tour of the home revealed:
- an isolation cart with personal protective equipment on the East Wing hallway was noted to be visibly soiled inside and out. This was confirmed by a housekeeping aide;
- a Floating care cart with resident care supplies on the Northeast Wing hallway was observed to be visibly soiled and contained one used and unlabeled hair brush in the drawer. A Registered Practical Nurse confirmed that the hair brush should not be there and was now unusable;
- the East Tub Room contained two unlabeled used brushes with hairs, three unlabeled deodorant sticks, a used tube of Silicone Cream, a used jar of Sunflower Body Butter cream and a used and unlabeled nail clipper. A Personal Support Worker confirmed that resident unlabeled personal hygiene items should not be there and it was removed;
- the North Tub Room contained one used and unlabeled razor, used and unlabeled and uncovered Secret Deodorant stick, used and unlabeled tube of Aim toothpaste and Crest toothpaste, used bar of soap, two used and unlabeled rusty nail clippers and a pair of rusty scissors;
- two North Tub room storage carts were observed to be visibly soiled inside and out. The drawers contained one used and unlabeled nail clipper, unlabeled Old Spice deodorant stick, unlabeled scissors and two unlabeled hair brushes with hairs. This was confirmed by a Personal Support Worker.

Observation of a bathroom shared by 4 residents revealed an unlabeled bed pan with no name stored on the back of the toilet and a bar of hand soap in a dish on the vanity not identified for use.

Observation of three shared resident bathrooms revealed unlabeled soap dishes with a bar of hand soap.

Interview with a Registered Practical Nurse and two Personal Support Workers confirmed the home's expectation is that staff are responsible for labeling all resident personal hygiene items. The Environmental Services Supervisor (ESM) revealed the expectation is that all isolation carts and care carts are cleaned by night staff. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Review of three Minimum Data Set (MDS) Assessments revealed Resident #15 had a significant change in bowel continence. Review of the MDS Quarterly Assessments revealed Resident #14 had a significant change in bowel continence. Review of the residents' clinical record revealed the absence of a documented continence assessment.

Interview with the Administrator and Resident Assessment Instrument (RAI) Coordinator confirmed there was no documented evidence of a completed clinically appropriate assessment tool for incontinence. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services, linens are maintained in a good state of repair and free from stains.

Observation of bed linens for eight resident beds revealed the bottom sheets were in disrepair with stains and/or multiple holes and runs in the middle and edge of the sheets.

The Environmental Services Manager confirmed that the bed sheets were not in a good state of repair and free from stains. Further interview with the Environmental Service Supervisor confirmed the home's expectation is that all residents' linens in disrepair or with stains are to be discarded and replaced by staff as part of the organized program of laundry services. [s. 89. (1) (c)]

WN #10: 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):
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Record review for Resident # 46 and Resident # 41 indicate the presence of a respiratory infection. The Administrator verified that there was a Respiratory Outbreak declared by Public Health in #2244-2015-020 and initiated on January 13, 2015 with a declaration of completion on January 30, 2015. The Administrator confirmed that there was not a Critical Incident filed to report the outbreak to the Director. [s. 107. (1) 5.]

Issued on this 22nd day of June, 2015

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

Original report signed by the inspector.