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

Division de la responsabilisation et de la performance du système de santé
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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
Oct 13, 2015	2015_229213_0046	022262-15 005223-14	Critical Incident System

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

RHONDA KUKOLY (213)

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): October 7 & 8, 2015

These critical incident reports (2729-000006-15 and 2729-000010-14 related to falls) were completed while in the home also completing complaint inspections 018689-15, 019526-15, and 020488-15 with Inspector #563.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Assessment Instrument (RAI) Coordinator, a Registered Nurse, four Registered Practical Nurses, three Personal Support Workers, and two Residents.

The Inspectors also made observations and reviewed health records, policies and other relevant documentation.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Observations on October 7 and 8, 2015 revealed Resident #103 had identified devices in use.

Record review of the plan of care for Resident #103 revealed no notation regarding the use of the identified devices.

Staff interview with the Administrator and the Resident Assessment Instrument (RAI) Coordinator on October 8, 2015 confirmed that there was no documentation in the plan of care for Resident #103 regarding the use of these devices. They confirmed the home's expectation that use of these devices should have been identified in the plan of care. [s. 6. (1) (c)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistive Service Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Observation of Resident #002 on October 7 and 8, 2015 by Inspector #563 revealed the Resident had identified devices in use on both days.

Staff interview with a Personal Support Worker (PSW) on October 7, 2015 with Inspector #563 confirmed Resident #002 did not have the ability to remove the identified devices without assistance. The PSW could not demonstrate how they knew to apply any of the identified devices in place.

Record review of the current care plan on October 8, 2015 for Resident #002 by Inspector #563 revealed there were no goals or interventions related to the use of the identified devices. Record review of the PSW kardex revealed there were no interventions related to the use of the identified devices in place.

Staff interview with two Registered Staff Members on October 8, 2015 with Inspector #563 confirmed there were no interventions in place related to the use of the identified devices, confirmed there was no monitoring or documentation in point of care (POC) by the PSWs and confirmed there were no consents in the Resident's chart for any of the devices in place.

Observation of Resident #103 on October 7 and 8, 2015 by Inspector #213 revealed the Resident had an identified device in use on both days.

Record review of the current plan of care for Resident #103 by Inspector #213 revealed there were no goals or interventions regarding the use of the identified device. Record review of the paper and electronic health record for Resident #103 revealed no consent related to the use of the identified device.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator October 8, 2015 with Inspector #213 confirmed Resident #103 did not have the ability to remove the identified device without assistance. They confirmed PSWs had no direction regarding the use of the device and that the device was a PASD. Staff interview with a Registered Staff Member on October 8, 2015 with Inspector #213 confirmed there was no consent related to the use of the identified device and no goals or interventions in the plan of care regarding the use of this device for Resident #103.

Staff interview by Inspector #213 and #563 with the Administrator revealed the Occupational Therapist (OT) would have approved and acquired consent for the use of the devices for Resident #002 and Resident #103, however this documentation was kept separate from the Residents' charts and not in the home. They confirmed that the above noted devices were considered PASDs for these Residents.

Staff interviews with Administrator and the RAI Coordinator and Inspectors #213 and #563 on October 8, 2015 confirmed the expectation that the use of PASDs must be noted in the plan of care and in point of care for PSW documentation. The Administrator also confirmed there was no documented evidence that consent was obtained for Resident #002 or #103 for the use of the identified devices because the home was unaware that consent was required for PASDs. [s. 33. (3)]

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 a Personal Assistive Service Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked and that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Observations on October 8, 2015 on the first floor revealed the medication cart parked in front of the nursing desk with the medication cart unlocked with no registered staff present or in sight of the cart. Three residents, three family members, a dietary aide, and three PSW's walked past the unlocked cart and construction workers were around the corner at the entrance to the home working during the time period of 11:24am and 11:50am with no registered staff present or in sight of the medication cart. All drawers of the cart were able to be opened and resident medications accessed, including the bottom drawer holding liquid medications, a partial bottle of alcohol, and the controlled substances bin holding numerous cards of controlled medications, was unlocked, able to be opened, and controlled substances accessed.

The Administrator was called, and at 11:50am the Administrator arrived at the nursing station and confirmed that the medication cart and controlled substances bin were both unlocked and unattended by registered staff. The Administrator confirmed the expectation that the controlled substances bin was and is to be locked inside the locked medication cart at all times when unattended by registered staff. [s. 129. (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 drugs are stored in an area or a medication cart that is secure and locked and that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

Issued on this 13th day of October, 2015

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

Original report signed by the inspector.