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
Jan 14, 2015	2014_163109_0037	T-046-14	Resident Quality Inspection

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 SQUIRES (109), JULIENNE NGONLOGA (502), THERESA BERDOE-YOUNG (596)

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): December 11, 12, 15, 16, 17, 18, 22, 2014.

During the course of the inspection, the inspector(s) spoke with the executive director, director of resident care (DOC), director of support services, director of quality and risk, clinical care leader, resident team coordinators, personal support workers (PSW), housekeeping aide, laundry aide, dietary aide, maintenance porter, food service supervisor (FSS), dietician (RD), registered nursing staff, residents, family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 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).

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

Review of resident #18's plan of care for a specified date, indicates the resident wears upper and lower dentures. The plan directs the staff to soak the dentures at bedtime and cleanse after meals.
The plan of care does not set out clear direction to staff to address resident's oral hygiene.
Interview with identified staff revealed that they do not have clear direction regarding resident's oral hygiene. [s. 6. (1) (c)]

2. The licensee 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 revealed resident #18 was identified to be at a high risk for falls and had experienced multiple falls and close calls for more than a 2 month period of time. The plan of care directs the staff to ensure the bed sensor is in place and the call bell is within reach.

On a specified date, a progress note stated that the fall sensor was not functioning

properly. On the next day, resident #18 had fallen and was found on the floor beside his/her bed.

On another later specified date, an interview with the resident revealed that he/she is to ring the bell for assistance when he/she wants to get out of bed. Observation revealed that the call bell was not within the resident's reach. Observation also revealed that the bed sensor alarm was not functioning because the power cord had come undone.

Interview with a PSW on a specified date, revealed that the bed alarm was not functioning in the morning and he/she had found the resident trying to get out of bed unassisted. The planned care was not provided as specified. [s. 6. (7)]

3. Record review of the plan of care revealed that resident #46 has difficulty swallowing. The plan of care directs the staff to position the resident at a 90 degree angle and ensure he/she remains upright for 30 minutes after the meal.

On a specified date, resident #46 was observed in his/her wheelchair positioned at the table at a 30 degree angle while being fed with the resident's chin and eyes oriented toward the ceiling.

Staff interview with a registered nursing staff revealed that the staff believed that a 30 degree angle was a proper position for resident #46 instead of 90 degrees as specified in the plan of care. [s. 6. (7)]

4. Record review of the plan of care for toileting for resident #52 directs the staff to ensure that two staff provide total assistance for toileting to ensure safety of the resident.

Interview with the direct care staff revealed that the resident is toileted by one staff which places the resident at risk. [s. 6. (7)]

5. The licensee failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it.

Record review and nursing staff interview revealed that on a specified date, resident #47's diet changed from regular to pureed texture. On a later specified date, the inspector observed a PSW offer resident #47 a regular texture meal. The SDM for resident #47 advised the staff of the error and the resident was then offered the

appropriate pureed texture. Review of the kardex used by dietary staff and PSW's during meal service revealed that the resident's diet was not updated to reflect the current diet order.

Interview with the food service supervisor confirmed that he/she was informed about the diet change a day prior, but did not change the kardex before lunch on the next day. [s. 6. (8)]

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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it, 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 policy instituted or otherwise put in place is complied with.

Review of the home's policy tilted Outbreak Management and dated April 2014, indicated that the basic elements of the isolation precaution is to supply proper personal equipment, and it requires additional precautions sign to be placed on the door, to inform POA/NOK, dietary and housekeeping.

On a specified date, the home was experiencing a respiratory outbreak. Several residents on an identified unit were isolated due to being infected with an identified organism. Observation of several of the affected resident rooms revealed the rooms did not have proper precaution signage placed on the door to alert anyone entering the room that personal protective equipment was required.

Interview with the clinical care leader (CCL) confirmed that the proper signs provided by public health were not posted.

On a specified date, resident #30's room had signage on the door and was in isolation due to an infection. The inspector observed that supplies of gloves were not available in the resident's room for personal protection. This was brought to the clinical care leader's attention, and he/she provided a box of gloves. [s. 8. (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 policy entitled Outbreak Management is complied with, to be implemented voluntarily.

WN #3: 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 on at all times.

Observation made on 2 specified dates, indicated that when the cord of the call bell in resident's #15's bathroom is pulled, the cord is pulled apart from the base and the call bell could not be activated.

Staff interview confirmed that the call bell in the resident #15's bathroom was not functioning. [s. 17. (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 resident-staff communication and response system is on at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

Record review of resident #23's plan of care addresses care of the dentures, but does not address the resident's oral hygiene at all. Interview with the resident and an identified staff confirmed that the resident completes his/her own oral care. [s. 26. (3) 12.]

2. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

Record review revealed resident #52 returned to the home from the hospital with a specified treatment. There was no plan of care in place for the specified treatment.

This was confirmed during an interview with the Director of Care. [s. 26. (3) 18.]

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 is based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene, and to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
Record review of the MDS assessment revealed resident #52 requires extensive assistance of 2 staff for transferring.

Review of the plan of care for resident #52 directs the staff to use a standing lift if the resident is not able to bear weight.

Staff interview confirmed that the standing lifts are designed for residents who are still able to bear weight.

Interview with the staff revealed the information on the plan of care lacks clarity regarding the resident's abilities to transfer and the type of transfer that is required to safely transfer the resident between positions. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene.

Review of the hand hygiene's training records for housekeeping and dietary staff revealed that 33 percent of the staff had not been trained in 2013 and that 50 percent had not been trained as of December 22, 2014.

This was confirmed during an interview with the director of support service. [s. 219. (4) (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 the retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene, 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 staff participate in the implementation of the infection prevention and control program.

On a specified date, an identified housekeeping aide was observed cleaning the toilet bowl and bathroom floor while wearing a pair of disposable gloves. The housekeeper then carried on to clean and sanitize the nursing station without changing the gloves or washing his/her hands.

On a specified date, an identified dietary aide was observed to clean the servery and change the garbage bag. The same staff member was observed to then proceed to remove the clean and sanitized dishes from the dishwasher. The inspector observed that the staff member did not wash his/her hands or changed his/her gloves before touching the clean dishes.

On a specified date, an identified dietary porter was observed handling the food waste containers from the dining areas. The staff member then removed the clean and sanitized items from the dishwasher without washing his/her hands or changing the gloves between these tasks.

Staff interview including the director of support service indicated that gloves should be changed between tasks and confirmed that hands should be washed regularly. [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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to have his or her personal health information kept confidential is fully respected and promoted.

On a specified date the inspector observed the registered nursing staff member administering medications in the lounge. The medication cart was sitting in the corridor with the computer screen open exposing residents' personal health information.

The staff member confirmed that the screen should be kept locked when the cart is unattended. [s. 3. (1) 11. iv.]

2. On a specified date, an identified nursing staff was observed placing the empty medication pouch into the regular garbage.

Interview with the nursing staff revealed that staff are directed to rinse the pouch before placing it in the garbage to erase the personal health information. The staff member confirmed that the information on the pouch is still visible after he/she rinsed the pouch and placed it in the garbage.

Interview with the director of care revealed that a new process had been implemented after the inspectors found personal health information exposed. [s. 3. (1) 11. iv.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is kept clean and sanitary.

On a specified date, the ceilings above the steam table on the first floor north building and above the fridge, on the fourth floor south building were observed to be covered with dust. The director of the support services confirmed the ceiling was not clean, and then sent a request to be cleaned by the end of the day. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Record review of resident #18's written care plan does not address oral care. Interview with resident #18 revealed that he/she does not receive oral care in the morning, and only receives it in the evening.

Interview with an identified PSW confirmed that oral care was not given to the resident in the morning of a specified date. [s. 34. (1) (a)]

2. The licensee has failed to ensure that the resident is offered an annual dental assessment subject to payment being authorized by the resident/SDM if payment is required.

Record review of resident #23's plan of care indicated that resident was not offered an annual dental assessment in 2013. Interview with the resident confirmed that he/she had not been offered a dental screening since 2011. [s. 34. (1) (c)]

WN #11: 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 failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review and resident interview revealed that the licensee failed to respond in writing to the following items brought forward to the management from the Residents' Council meetings.

In September 2014 the Residents' Council raised concerns about the menu being posted a day late, and the chairs being dirty.

In October 2014 the Residents' Council requested large print for the minutes, staff shortages for days and evenings, residents not informed of outings and residents' showers being rushed.

In November, 2014 the Residents' Council raised concerns that the table rotation was not being followed at mealtimes and that utensils and other items went missing from the dining room tables.

The President and Vice President of the Residents' Council revealed that concerns raised by the Council are responded to by the licensee, however, the above identified concerns and suggestions were not responded to in writing, neither of the residents interviewed were certain that the concerns had been dealt with and what was done to address the concerns. [s. 57. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle include alternate choices of desserts at lunch and dinner.

Observation made on a specified date, indicated that residents on a calorie reduced/diabetic modified diet were not offered a second choice of desert.

A review of the therapeutic diabetic menu and nutrient analysis revealed that the menu on Tuesday of week three, does not provide alternate choice of desert for the calorie reduced/diabetic modified diet.

This was confirmed with the FSM. [s. 71. (1) (c)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are appropriate furnishings and equipment in resident dining areas, including tables at an appropriate height to meet the needs of all residents.

Staff interview and observation made on a specified date, confirmed that resident # 48 was sitting in his/her wheelchair at the dining room table, and that the table height was not appropriate to meet his/her needs. The table height was much higher than the resident. [s. 73. (1) 11.]

Issued on this 15th day of January, 2015

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

Original report signed by the inspector.