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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 27, 2018	2018_370649_0002	002501-16, 011290-16, 031739-16, 035165-16, 004825-17, 013188-17, 014311-17	Critical Incident System

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

JULIEANN HING (649), NITAL SHETH (500)

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): January 31, February 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 23, 26, 27, and 28, 2018.

The following Critical Incidents System (CIS) were inspected:
Log #011290-16/ CIS # 2852-000011-16 related to allegation of staff to resident abuse
Log #031739-16/ CIS #2852-000015-16 related to falls prevention and management
Log #002501-16/ CIS # 2852-000003-16 related to allegation of staff to resident abuse
Log #035165-16/ CIS # 2852-000021-16 related to allegation of resident to resident abuse
Log #00485-17/ CIS # 2852-00007-17 related to allegation of resident to resident abuse
Log #03188-17/ CIS #2852-000028-17 related to responsive behaviours
Log #014311-17/ CIS #2852-000029-17 related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Directors of Resident Care (DRCs), Resident Team Coordinators (RTCs), Nurse Managers (NMs), Physician, Registered Nurses (RNs), Physiotherapist (PT), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), Staffing Coordinators, Supervisor of Health and Safety, Behavior Support Outreach Team (BSOT), Residents and Family members.

During the course of the inspection, the inspector observed staff to resident interactions, resident to resident interactions, reviewed relevant policies, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
4 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. (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).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

On February 8, 2018, resident #002 was observed in their mobility device and the mobility device was observed tilted to almost 180 degrees.

A review of resident #002's care plan indicated the use of a tilt mobility device as a Personal Assist Safety Device (PASD) while in the mobility device to promote skin integrity and comfort.

Interview with Personal Care Assistant (PCA) #116 revealed resident #002's mobility device is tilted when they are not being supervised to avoid the resident putting their feet on the floor and trying to stand.

Interview with Registered Practical Nurse (RPN) #127 revealed they would tilt the resident's mobility device ranging from 50 to 70 degrees for the resident's comfort.

Interviews with PCA #116, RPN #127, Registered Nurse (RN) #115, Resident Team Coodinator (RTC) #121 and Director of Resident Care (DRC) #114 revealed that resident #002's care plan did not provide clear directions to staff on what degree the resident's mobility device should be tilted. [s. 6. (1) (c)]

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

A review of the Critical Incident System (CIS) report submitted in November 2016, indicated resident #001 sustained a fall in October 2016, and after the fall noted to have difficulty with weight bearing and pain. An x-ray indicated an injury and the resident was transferred to the hospital.

A review of resident #001's progress notes in October 2016, indicates documentation of pain after the resident fell.

RPN #112 who assessed the resident when they fell and who the family reported the resident was having pain in October 2016, was not available for an interview. DRC #114 told the inspector that NM #120 had spoken with RPN #112 who had revealed when resident #001's family had reported the resident was having pain to an identified body area on an identified date in October 2016, had not informed the physician.

Interview with RN #117 revealed that when the resident continued to complain of pain the Nurse Practitioner (NP) or physician should have been notified the next day after the fall.

Interview with the DRC #114 revealed that communication with the physiotherapist (PT) should have been done sooner to have their expertise in assessing the resident.

The above interviews demonstrate that staff failed to collaborate with each other in the assessment of the resident's pain after the resident fell in October 2016. [s. 6. (4) (a)]

3. A review of CIS report submitted in June 2017, indicated that resident #002 had an un-witnessed fall and was found lying on the floor in their room and had sustained two areas of altered skin integrity to an identified body part. After the fall staff reported that resident was reluctant to move or bend their legs, PT assessed the resident and noted pain to an identified body part and the resident was transferred to the hospital for assessment.

Record review of the home's point of care (POC) documentation completed by the PCA indicated the resident had pain two days in June 2017 after they fell.

In June 2017 after the resident fell there was a meeting with the resident's SDM who requested to have the resident's pain medication put on hold and according to the MAR the pain medication was put on hold.

Interview with RPN #127 who processed the order to hold the resident's pain medication revealed that a pain assessment had not been documented prior to putting the pain medication on hold and stated if the resident was having pain the PCA would have reported this verbally. The RPN was not aware of the POC documentation that the resident had pain two days in June after they fell.

Interviews with RTC #121 and DRC #114 revealed they would expect staff to collaborate in the assessment of the resident's pain before the medication was put on hold. [s. 6. (4) (a)]

4. 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 of care.

On February 8, 2018, resident #002 was observed in their mobility device tilted to almost 180 degrees. This was immediately brought to the attention of RN #115 who released the mobility device from the tilted position.

Record review indicated that resident #002 was is at risk for falls. According to the care

plan staff were directed to bring the resident to nursing station for close monitoring if the resident tries to get out of their bed as a fall prevention intervention.

While conducting an interview with PCA #116 in February 2018, resident #002 sustained a fall from their mobility device in an identified area of the home, no injury was observed. According to the PCA resident mobility device has to be tilted when the resident is not being supervised as they will get up out of the mobility device when it is in an upright position.

Interview with RN #115 revealed that they had taken the resident to an identified area of the home to be monitored and had left the resident unsupervised in their mobility device tilted approximately 30 to 45 degrees.

Interview RTC #121 revealed resident #002's care plan had not been followed as the resident should have been brought to the nursing station for monitoring.

Interview with the DRC #114 revealed that resident #002's care plan was not being followed as the resident's mobility device should not have been left in an upright position and the resident should have been provided intermittent supervision. [s. 6. (7)]

5. A review of CIS report submitted in April 2016, revealed that resident #013 reported that PCA #140 hit the resident during care and provided rough care.

The resident was not available for an interview as the resident was discharged.

A review of the resident #013's written plan of care revealed that the resident required extensive assistance from two people for all kinds of care.

Interview with PCA #140 revealed that they did not hit the resident, however the care was provided by one person only because they were not aware of the resident's plan of care requiring two people assistance for care being a casual staff in the home.

Interview with RPN #141 revealed that the resident reported that PCA #140 hit them and provided rough care and the resident required two people assistance all the time. PCAs are expected to get familiar with the resident's plan of care and follow it.

A review of the home's investigation revealed that PCA #140 did not follow the resident's plan of care and did not use two people during care being unaware of the resident's plan

of care.

Interviews with RTC #123 and DRC #126 revealed that staff are expected to be aware of the resident's plan of care and able to follow it while providing care to the resident [s. 6. (7)]

6. The licensee has failed to ensure if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

A review of CIS report submitted in November 2016, indicated resident #001 sustained a fall in October 2016, and after the fall noted to have difficulty with weight bearing and pain. An x-ray indicated an injury and the resident was transferred to the hospital.

Observations on February 7 and 12, 2018, revealed resident #001 was up in their mobility device with the safety device undone and demonstrated to the inspector they were able to open and close the safety device.

According to the care plan dated the resident was identified at risk of falls and used a safety device as a fall prevention intervention.

Review of progress notes indicated resident #001 sustained falls from the mobility device after the safety device had been initiated.

Interviews with RPN #119 and RTC #121 revealed that in February 2018, the resident care plan was updated to reflect that resident #001 was able to undo the safety device. They confirmed that this intervention was not effective in preventing falls as the resident was able to remove the safety device.

Interview with DRC #114 revealed the safety device was not effective in preventing falls and the resident should have been kept at the nursing station for closer supervision. [s. 6. (10)]

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, to ensure that 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, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care, to ensure if the plan of care is being revised because care set out in the plan has not been effective, ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from sexual abuse by anyone.

A review of CIS report submitted in February 2017, revealed a PCA witnessed resident #004 touching resident #006's and immediately separated the two residents. Approximately 30 minutes later resident #004 was exhibiting a responsive behaviour with resident #007.

In February 2017, PCA #104 witnessed resident #004 touching resident #006. According to the PCA resident #004 appeared confused when told they should not be doing this as the resident thought resident #006 was their spouse. The residents were immediately separated and resident #004 taken to their room.Resident #006 was unable to recall the

incident.

A second incident occurred involving resident #004 and another resident. PCA #102 witnessed resident #004 and resident #007 engaging in a responsive behaviour in an identified area of the home and immediately reported this to RPN #107 and the residents were immediately separated. According to the PCA neither resident is able to consent to this behaviour as both are confused. Resident #007 was unable to recall the incident.

Resident #004 is no longer in the home and was not available for an interview.

Interview with RPN #107 revealed they became aware of the first incident between residents #004 and #006 when PCA #104 had reported it to the night and day nurses at the morning report and initiated monitoring for resident #004 of checking every 15 minutes. According to the RPN they could not recall if they had immediately reported the first incident between residents #004 and #006 to the RTC.

Interview with RTC #123 revealed that the first incident between residents #004 and #006 in February 2017, was not immediately reported to them and only became aware of the first incident after the second incident had occurred. The RTC told the inspector the second incident could have been prevented if they were informed of the first incident earlier and one to one monitoring should have been started by the short shift PCA for resident #004. According to the RTC residents #006 and #007 were not protected from abuse.

Interview with DRC #126 revealed that resident #004 resided on another unit and as the resident started to decline cognitively a decision was made to transfer the resident to a different unit. After resident #004 was transferred they began to touch co-residents. According to the DRC the home does not have a policy in place to assess capacity of residents in order to obtain consent prior to sexual activity. The DRC further revealed that neither residents would be able to provide consent to the behaviour and confirmed that the home had not protected residents #006 and #007 from abuse. [s. 19. (1)]

2. A review of the CIS report submitted in December 2016, revealed during safety check staff member heard some whispering from one of the rooms. When staff member went to check, resident #010 was found sitting on the edge of the bed and resident #011 was found in front of resident #010.

A review of resident #010's written plan of care revealed that the resident was identified

with a particular responsive behaviour, staff to monitor the resident and communicate in a calm manner, and remove from the common areas.

Interview with PCA #104 revealed that both residents involved in the incident were confused. Interview with RPN #130 revealed that both residents were confused and were not able to consent for the responsive behaviour, and were not aware of the consequences of their action.

Interviews with RTC #123, Behaviour Support Outreach Team (BSOT) #131, and DRC #126 revealed that the incident was abuse, as both residents were not able to consent and aware about the consequences of their action. [s. 19. (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 protect residents from sexual abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

A review of CIS report submitted in February 2017, revealed a PCA witnessed resident #004 touching resident #006 and immediately separated the two residents. Approximately 30 minutes later resident #004 was exhibiting a responsive behaviour with resident #007.

A review of the home's policy titled Abuse and Neglect, policy #M1-010 last reviewed on February 15, 2017, revealed that any board member/ employee/ volunteer who has knowledge of an alleged, suspected or witnessed act of abuse or neglect will immediately report it to the direct supervisor and inform the Nurse Manager/Designate who will notify the Director of Care and Vice President, Residential and Community Care. The Vice President, Residential and Community Care will report the incident to the President and Chief Executive Office (CEO). The Director of Care/designate will inform the Ministry of Health and Long Term Care (MOHLTC) using the Mandatory Critical Incident Systems (MCIS) reporting process immediately upon becoming aware of the incident.

Interview with RPN #111 who had observed resident #004 and resident #010 having a responsive behaviour in February 2017, in the hallway revealed they had not immediately reported the incident to the nurse manager (NM).

Another incident occurred in February 2017, involving residents #004 and #006. According to PCA #104 who witnessed the incident observed resident #004 touching resident #006 and immediately reported this to RPN #107. RPN #107 could not recall if they had immediately reported this incident to the RTC.

Interview with RTC #123 revealed that the incident between residents #004 and #006 in February 2017, had not been immediately reported to them. The RTC revealed they had only found out about this incident when they had gone to the unit about a second incident involving residents #004 and #007.

Interview with the DRC #126 revealed that the two incidents in February 2017 should have been immediately reported and confirmed that the home's policy was not followed. [s. 20. (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 without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care.

On February 8, 2018, resident #002 was observed in their mobility device tilted to almost 180 degrees. This was immediately brought to the attention of the Registered Nurse (RN) #115.

A review of the home's policy titled Restraint Minimization and Use, policy #M2-970 last reviewed on February 15, 2017, indicated if a wheelchair is tilted to prevent a person from leaving the wheelchair, it is considered restraining with a physical device.

Record review of resident #002's plan of care did not indicate the use of a tilt mobility device as a restraint. Further record review and interviews with the PCA and the nurse confirmed resident #002 is able to get up out of the mobility device when it is not tilted.

Interview with PCA #116 in February 2018, indicated they had observed resident #002

up in their mobility device tilted to almost 180 degrees and had spoken with the resident. The PCA revealed that the resident had been left in the tilted position by the day shift. According to the PCA resident #002 should not have been left in this position and told inspector that the tilt mobility device is a restraint.

Interview with RN #115 in February 2018, revealed that resident #002's mobility device was tilted a few degrees less than 180 degrees and confirmed that the tilted mobility device was a restraint as the resident is able to get up out of the mobility device on their own when it is not tilted. The nurse further revealed that they are not comfortable putting the resident's mobility device in this titled position as the resident is at risk of falling. The nurse confirmed there was no order from the physician or approval from the resident's SDM for the use of the tilt mobility device restraint.

Interview day PCA #129 revealed that they had tilted resident #002's mobility device to almost 180 degrees in February 2018, on the day shift and told the inspector they got busy and forgot to go and check on the resident.

Interview with RPN #127 revealed that when resident mobility device is tilted to almost 180 degrees it is a restraint to the resident and told the inspector that there was no approval from the physician or the resident's SDM for use of the tilt mobility device.

Interviews RPN #127, RTC #121 and DRC #114 revealed that tilting resident #002's mobility device to almost 180 degrees in February 2018, is a restraint and was not included in the resident's plan of care. [s. 31. (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 a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Review of progress notes indicated there was an incident of abuse between residents #004 and #010 in February 2017, that were not immediately reported to the Ministry.

Interview with DRC #126 revealed they thought consent was implied based on residents observation and did not regard the the above incident in February 2017, as abuse and therefore had not immediately reported the incident to the Ministry. [s. 24. (1)]

WN #6: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, failed to make a report in writing to the Director setting out the names of any staff members or other persons who were present at or discovered the incident.

A review of CIS report submitted to the MOHLTC in February 2017, related to resident to resident abuse. According to this report a PCA witnessed resident #004 touching resident #006 and immediately separated the two residents. Approximately 30 minutes later resident #004 was seen by a PCA touching resident #007.

Review of the amended CIS, revealed that PCA #102 who witnessed residents #004 and resident #007 touching name was not mentioned on the CIS report.

Interview with RTC #123 and DRC #126 revealed that the PCA name who had witnessed residents #004 and resident #007 touching was not mentioned on the CIS report. [s. 107. (4) 2.]

Issued on this 13th day of April, 2018

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

Original report signed by the inspector.