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
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 14, 2013	2013_182128_0012	L-000233-13	Follow up

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

RUTH HILDEBRAND (128), JOAN WOODLEY (172)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 6 - 8, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), Assistant Director of Care, RAI Coordinator, 4 Registered Nurses, 5 Registered Practical Nurses, 8 Personal Support Workers, Dietary Compliance Lead, Registered Dietitian, Acting Director of Dietary Services, 2 Dietary Aides and 1 Physiotherapy Assistant.

During the course of the inspection, the inspector(s) observed residents and the care provided to them. Partial meal and partial snack services were also observed. The inspectors reviewed clinical records including documentation of care provided to residents, as well as policies and procedures pertinent to the inspection.

The following Inspection Protocols were used during this inspection:
Dining Observation

Falls Prevention

Nutrition and Hydration

Pain

Safe and Secure Home

Skin and Wound Care

Snack Observation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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. A clinical record review for an identified resident revealed the resident continues to have a chronic poor fluid intake.
The Medication Administration Record had a special instruction documented related to providing fluids.
Three registered nursing staff gave three different answers when queried as to the expectations related to this intervention.
The Dietary Compliance Lead acknowledged that this order does not provide clear direction to staff. [s. 6. (1) (c)]

2. A clinical record review for an identified resident revealed the plan of care and the assessed need documented in the annual assessment have inconsistencies related to the amount of assistance required with eating. It ranged from total assistance to constant encouragement and/or extensive assistance with eating. The dietary roster/kardex in the dining room was also inconsistent.
The Dietary Compliance Lead acknowledged there were inconsistencies between the assessed need and plan of care. The home's expectation is that nursing and dietary be consistent in the development and implementation of the plan of care.
The Director of Care also acknowledged that interventions in the care plan had not been updated since 2009. [s. 6. (4) (b)]

3. A clinical record review revealed that an identified resident continues to have chronic constipation and did not have a bowel movement until day 7 with "much discomfort" noted in the progress notes.
A Dietary Aide stated that the resident does not receive any dietary interventions for constipation and a review of the dietary roster in the servery revealed that there were no interventions documented.
The Registered Dietitian stated the same day that she initiated an intervention for the resident to receive prune juice daily, at breakfast, November 2012, to help alleviate the discomfort and complications related to constipation. However, this intervention was never implemented.
The resident was not provided prune juice at an observed breakfast meal despite Inspector #128 identifying the missing intervention the day before.
The Director of Care acknowledged that the resident was not provided the prune juice as set out in the plan of care. The resident was still not provided with prune juice despite the Director of Care discussing this with staff during the breakfast meal after the inspector brought this to the home's attention. [s. 6. (7)]

4. A clinical record review for an identified resident revealed the resident had a physician's order to be provided 120 ml Resource 2.0 when a meal was refused. The resident is at high nutritional risk related to significant ongoing weight loss.
Review of the food intake records in Point of Care revealed that the resident refused 6 meals in an 8 day period.
Review of the Medication Administration Record revealed that the resident was not provided with the ordered 120 ml Resource 2.0 any of the 6 times meals were refused. [s. 6. (7)]

5. a. Review of Point of Care records for an identified resident revealed that there was nothing documented for 6 meals in an 11 day period. This resident is at high nutritional risk related to ongoing weight loss and poor food intake.
The Dietary Compliance Lead confirmed the expectation was that the provision of care, as set out in the plan of care, must be documented and that consumption of food and fluids must be documented after each meal and snack.
She acknowledged that no consumption had been documented for this resident for the 6 meals identified.

b. Point of Care records reviewed for 4 identified residents revealed that outcomes of care were not documented accurately.
Observation of snacks on May 7, 2013 revealed the following:
One resident – recorded as 175 mls fluid at morning snack but was observed to be provided only 120 mls thickened fluid;
One resident – recorded as 175 mls fluid at morning snack but was observed to be provided only 120 mls thickened fluids;
- recorded as 100% eaten for pm snack but resident was not offered a snack; and fluid at pm snack was recorded as 175 mls fluid, however, resident refused a beverage at pm snack;
One resident – recorded as 175 mls fluid at pm snack but was observed to be provided 120 mls;
One resident - recorded as 25% eaten for pm snack but resident was not offered a snack; and fluid at pm snack was recorded as 525 mls fluid, however, resident refused a beverage at pm snack.
The RAI Coordinator acknowledged that the documentation was done incorrectly. She confirmed that the home is reviewing the way meals and snacks are documented in Point of Care. [s. 6. (9)]

6. The plan of care was not reviewed and revised when an identified resident's care needs changed.
Post hospitalization the care plan had not been updated to reveal a change in mobility and transfer needs.
This was confirmed by a Registered staff member.
The Director of Care revealed the home's expectation is that when there is a significant change in a resident's condition, post hospitalization, that a 24 hour care plan similar to the admission 24 hour care plan be developed, printed and placed in the report book so that it can be read at report time, on all shifts for the next 7 days. This is done so that all staff are aware of the changes in care needs.
The expectation is that the Registered Nurses would oversee and ensure this was done.
The registered staff on all shifts are expected to assist with the completion of this 24 hour care plan.
The Director of Care confirmed this 24 hour care plan had not been done for the identified resident. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 plans of care for each resident set out clear directions to staff and others who provided direct care to residents; 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; the care set out in the plan of care is provided to the resident and the provision and outcomes of care set out in the plan of care are documented, 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. There were three policies in place related to hydration and monitoring of food and fluid which were inconsistent with each other and none were being complied with. The documented fluid amounts in both hydration policies did not match the therapeutic menu that was currently being used for meals and snacks.
Hydration Policy #DTY-11-430, dated Sept 2009 and Hydration of Residents policy DTY-II-496, dated May 2013, were inconsistent related to when residents were deemed to be at hydration risk.
The Acting Director Dietary Services and the Dietary Compliance Lead both indicated that the Monitoring Food and Fluid Intake policy # DTY-1-240, dated December 2011 does not reflect the actual practices in the home. They recognized that it was imperative that the hydration policy match the therapeutic menu and that a policy must be available to guide staff related to hydration.
They both confirmed awareness of the high risk of not having an evaluation system in place to monitor food and fluid intake for residents who are at risk. [s. 8. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. An identified resident was observed with his/her breakfast meal and beverages sitting in front of him/her. The resident sat for 20 minutes with no assistance and/or encouragement provided despite the need for assistance documented in the plan of care.
The Director of Care acknowledged the amount of assistance provided did not meet the resident's needs. [s. 73. (1) 9.]

2. Inspector #128 identified, to the home, that an identified resident was not being provided the assistance that he/she required to eat a meal. The resident is at high nutritional risk with documented risk of choking. A member of the registered nursing staff was then observed, in an unsafe feeding position, assisting the resident with eating, placing the resident at potential risk of choking.
The Director of Care, also, observed the registered staff member and indicated the expectation was that staff are at eye level, while assisting residents with eating, to ensure that they are being fed safely. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. There have been two compliance orders previously identified, March 27, 2012 and September 20, 2012, related to each organized program required under section 48 of the regulations having a written description of the program that includes its: goals and objectives; relevant policies, procedures, protocols, methods to reduce risk, methods to monitor outcomes and protocol for referral of resident to specialized resources where required.
The compliance order re-issued September 20, 2013 requested the preparation, submission and implementation of a plan for achieving compliance to ensure the required programs were developed.
The compliance plan submitted, to the MOHLTC, stated:
Skin and Wound Care Program will be implemented by October 21, 2012.
A Falls Prevention program will be implemented by November 30, 2012.
A Pain and Palliative Care Program will be implemented by Dec. 31, 2012
A Continence Care Program will be implemented by October 31, 2012.

Three of the four (75%) required programs, including Pain Management, Skin and Wound Care and Falls Prevention and Management were reviewed.
Non-compliance was found to continue with the Pain Management Program.
Pain assessments were not completed on an identified resident other than on admission. A topical analgesic/anti-inflammatory was ordered for pain. Two months later physiotherapy was ordered to address pain. A month after that a narcotic was ordered for pain.
No further pain assessments were completed, as per the home's policy/Pain Management and Palliative Care Program, dated October 2012, despite ongoing pain documented.
This was confirmed by the Director of Care. [s. 30. (1) 1.]

2. Non-compliance was found to continue with the Skin and Wound Care Program.
The Director of Care and the registered nursing staff member designated as the Skin and Wound Care champion revealed:
-weekly skin assessments are to be completed in the assessment section of Point Click Care using the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. The expectation was that the Registered Practical Nurse, working on Tuesday or Wednesday, would do the weekly assessment when the resident had a bath or had a dressing change scheduled. Additionally, the wound care champion would complete an assessment at least monthly.
Review of two identified resident's health records did not reveal documented weekly

assessments using the Point Click Care skin and wound care assessment.
Review of the home's listing of residents with open areas did not include one of the identified resident's wounds.
The Assistant Director of Care revealed education on the Skin and Wound Care program was scheduled for the month of June 2013. To her knowledge, no skin and wound education had been done in 2013, thus far. [s. 30. (1) 1.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. An identified resident's care plan states" Ensure call bell is within reach at all times".
Observations revealed the call bell was hanging behind the bedside table and as such the resident could not access it.
This was confirmed by a Registered staff member. [s. 17. (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 the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Residents exhibiting altered skin integrity did not receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
The Director of Care and the Skin and Wound Care champion revealed that the weekly skin assessment should be completed in the assessment section using the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment in Point Click Care. Documenting a note in the progress notes is not required. Weekly assessments for an identified resident were not completed. This was verified by the Director of Care. [s. 50. (2) (b) (i)]

2. Weekly skin assessments were not completed on another identified resident using a clinically appropriate assessment instrument. Chart review revealed the area had been identified and yet the Annual Head to Toe Assessment that was completed 3 days later did not reference the area at all. No further skin assessments were found during the inspection. This was verified by the Director of Care. [s. 50. (2) (b) (i)]

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 each resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. A new Hydration of Residents policy # DTY-II-496, dated May 2013 was reviewed with the Director Dietary Services and the Dietary Compliance Lead.
The Dietary Compliance Lead confirmed that it was not an accurate reflection of what was being done in the home and that it was not developed in consultation with the dietitian who is a member of the staff.
She stated that none of the policies and procedures related to the nutrition care and dietary services and hydration programs had been reviewed/or developed by the home's Registered Dietitian. [s. 68. (2) (a)]

2. A review of documentation in Point of Care confirmed that the home has a system in place to monitor food and fluid intake of residents.
However, the Dietary Compliance Lead and the Director of Care confirmed that the system that was being used is no longer in place and currently there is no evaluation of the food and fluid records to identify residents who are at risk related to nutrition and hydration.
The Registered Dietitian is in the process of creating a process to identify residents who had inadequate or compromised food and fluid intake.
The Dietary Compliance Lead acknowledged the priority to develop an evaluation system to monitor food and fluid intakes. [s. 68. (2) (d)]

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 development and implementation of policies and procedures related to the nutrition care and dietary services and hydration programs is done in consultation with a registered dietitian who is a member of the staff of the home; and to ensure that a system to evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration is developed, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. Two identified residents were not offered an afternoon snack.
A Personal Support Worker and the Dietary Compliance Lead confirmed the expectation that all residents are offered an afternoon snack daily. [s. 71. (3) (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 all residents are offered a snack in the afternoon and the evening, to be implemented voluntarily.

Issued on this 14th day of May, 2013

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

RUTH HILDEBRAND

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTH HILDEBRAND (128), JOAN WOODLEY (172)
Inspection No. / No de l'inspection :	2013_182128_0012
Log No. / Registre no:	L-000233-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 14, 2013
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	KENSINGTON VILLAGE 1340 HURON STREET, LONDON, ON, N5V-3R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~LESLIE HANCOCK~~ MICHAEL SCHMIDT

To SHARON FARMS & ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_087128_0018, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b).

The plan must include how residents will be reassessed and plans of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

The plan must include:

- confirmation with immediate dates that the written plan of care for the identified resident was reviewed and revised to ensure that staff are aware when care needs change.
The plan will also include how plans of care, for all residents of the home, will be reviewed and revised on an ongoing basis when the resident's care needs change or the care set out in the plan is no longer necessary and how the licensee will ensure that the care set out in the plan will be provided to the residents of the home.

The plan must also include timelines, who is responsible for each task and who will be responsible for monitoring this on an ongoing basis, both in the short term and long-term.

Please submit the plan, in writing, to Ruth Hildebrand, Long Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance and Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca by June 15, 2013.

Grounds / Motifs :

1. There have been two previous compliance orders written March 27, 2012 and September 20, 2012 related to residents not being reassessed and the plan of care reviewed and revised as care needs changed or care set out in the plan was no longer necessary.

The plan of care was not reviewed and revised when an identified resident's care needs changed.
Post hospitalization the care plan has not been updated to reveal a change in mobility and transfer needs.
This was confirmed by a Registered staff member.
The Director of Care revealed the home's expectation is that when there is a significant change in a resident's condition, post hospitalization, that a 24 hour care plan similar to the admission 24 hour care plan be developed, printed and placed in the report book so that it can be read at report time, on all shifts for the next 7 days. This is done so that all staff are aware of the changes in care needs.
The expectation is that the Registered Nurses would oversee and ensure this was done.
The registered staff on all shifts are expected to assist with the completion of this 24 hour care plan.
The Director of Care confirmed this 24 hour care plan had not been done for the identified resident.
(172)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_087128_0018, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 8(1) (b) to ensure that there are policies implemented in accordance with applicable requirements under the Act and that they are complied with.

The plan must include who is responsible ensuring that the policy related to food and fluid monitoring is developed to reflect the home's current practice. It must indicate who is responsible for ensuring food and fluid amounts are recorded and evaluated on an ongoing basis.
The plan must include when and how education will be provided to all nursing and dietary staff related to hydration and food and fluid documentation/ monitoring, including evaluation of food and fluid intake.
Additionally, the submitted plan must demonstrate that the licensee has an ongoing system in place to monitor compliance, with food and fluid monitoring and evaluation, including who will be responsible for the monitoring.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor,London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by May 28, 2013.

Grounds / Motifs :

1. There have been two previous compliance orders written March 27, 2012 and September 20, 2012 related to policies not being complied with and/or in implemented.

There were three policies in place related to hydration and monitoring of food and fluid which were inconsistent with each other and none were being complied with. The documented fluid amounts in both hydration policies do not match the therapeutic menu that is currently being used for meals and snacks.
Hydration Policy #DTY-11-430, dated Sept 2009 and Hydration of Residents policy DTY-II-496, dated May 2013, are inconsistent related to when residents are deemed to be at hydration risk.
The Acting Director Dietary Services and the Dietary Compliance Lead both indicated that the Monitoring Food and Fluid Intake policy # DTY-1-240, dated December 2011 does not reflect the actual practices in the home. They recognized that it is imperative that the hydration policy must match the therapeutic menu and that a policy must be available to guide staff related to hydration.
They both confirmed awareness of the high risk of not having an evaluation system in place to monitor food and fluid intake for residents who are at risk.
(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
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).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 73 (1) to ensure that:
Residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan must include who will be responsible for ongoing monitoring to ensure that a sustainable system is put in place to monitor meal and snack service to safeguard that residents are assisted/fed safely at all times, including safe positioning.

The plan must also identify how and when education will be provided to all staff, including registered nursing staff, and who will be responsible for providing the education.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by May 28, 2013.

Grounds / Motifs :

1. A previous written notification and voluntary plan of correction were issued, in March 2013, related to unsafe assistance provided with eating. (128)

2. Inspector #128 identified, to the home, that an identified resident was not being provided the assistance that he/she required to eat at a meal. The resident is at high nutritional risk with documented risk of choking. A member of the registered nursing staff was then observed, in an unsafe feeding position, assisting the resident with eating, placing the resident at potential risk of choking.
The Director of Care, also, observed the registered staff member and indicated the expectation was that staff are at eye level, while assisting residents with eating, to ensure that the are being fed safely. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 004

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order /
Lien vers ordre existant: 2012_087128_0018, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 30 (1) (b).

1. The plan must ensure that the following interdisciplinary programs are developed and implemented in the home:

a) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

b) A pain management program to identify pain in residents and manage pain.

2. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

3. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

4. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

5. The licensee shall keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The plan must include how staff will be provided education for each of these programs including immediate education related to communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

Please submit the plan in writing to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by May 28, 2013.

Grounds / Motifs :

1. Non-compliance was found to continue with the Home's Skin and Wound Care Program.
Staff interview with Director of Care and the Skin and Wound Care champion revealed:
the weekly skin assessment are to be completed in the assessment section of

Point Click Care using the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. The expectation was that the Registered Practical Nurse working on Tuesday or Wednesday would do the weekly assessment when the resident had a bath or had a dressing change scheduled. Additionally, the wound care champion would complete an assessment at least monthly.
Review of two identified resident's health records did not reveal documented weekly assessments using the Point Click Care skin and wound care assessment.
Review of the home's listing of residents with open areas did not include one of the identified residents wounds.
Interview with Assistant Director of Care revealed education on the Skin and Wound Care program was scheduled for the month of June 2013. To her knowledge, no skin and wound education had been done in 2013 thus far.
(172)

2. There have been two compliance orders previously identified, March 27, 2012 and September 20, 2012, related to each organized program required under section 48 of the regulations having a written description of the program that includes its: goals and objectives; relevant policies, procedures, protocols, methods to reduce risk, methods to monitor outcomes and protocol for referral of resident to specialized resources where required.

The compliance order re-issued September 20, 2013 requested the preparation, submission and implementation of a plan for achieving compliance to ensure the required programs were developed.
The compliance plan submitted, to the MOHLTC, stated:
Skin and Wound Care Program will be implemented by October 21, 2012.
A Falls Prevention program will be implemented by November 30, 2012.
A Pain and Palliative Care Program will be implemented by Dec. 31, 2012
A Continence Care Program will be implemented by October 31, 2012.

Three of the four (75%) required programs, including Pain Management, Skin and Wound Care and Falls Prevention and Management were reviewed.
Non-compliance was found to continue with the Pain Management Program.
Pain assessments were not completed on an identified resident other than on admission. A topical analgesic/anti-inflammatory was ordered for pain. Two months later physiotherapy was ordered to address pain. A month after that a

narcotic was ordered for pain.
No further pain assessments were completed, as per the home's policy/Pain Management and Palliative Care Program, dated October 2012, despite ongoing pain documented.
This was confirmed by the Director of Care.

(172)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of May, 2013

Signature of Inspector / Signature de l'inspecteur : RUTH HILDEBRAND

Name of Inspector / Nom de l'inspecteur : RUTH HILDEBRAND

Service Area Office / Bureau régional de services : London Service Area Office