Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
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Telephone: (416) 325-9660
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2021	2020_808535_0016	001416-20, 003445-20, 004771-20, 007871-20, 007971-20, 008010-20, 009037-20, 014349-20, 014371-20, 022596-20, 023466-20	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

VERON ASH (535)

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): December 17, 18, 21, 24, Off-site December 22, 23, 2020 and January 8, 2021.

The following intake were completed during this inspection:

Log #023466-20 was related to fall;
Log #022596-20 was related to fall;
Log #007971-20 was related to fall;
Log #014371-20 was related to fall;
Log #009037-20 was related to fall;
Log #004771-20 was related to fall;
Log #003445-20 was related to fall;
Log #001416-20 was related to fall;
Log #008010-20 was related to abuse;
Log #007871-20 was related to abuse; and
Log #014349-20 was related to compliance order (CO) #001 from inspection #2020_641665_0009 regarding s. 6. (7) with compliance due date October 30, 2020.

During the course of the inspection, the inspector(s) spoke with both Directors of Care (DOC), Manager of Residents Safety and Falls Lead (MRS), Nurse Managers (NM), registered staff (RN/RPN), personal care associate (PCA) and substitute decision-makers (SDM).

During the course of the inspection, the inspector conducted observations of resident home areas and staff to resident interactions, reviewed education and clinical health records, treatment and medication administration records, staffing schedule, internal investigation notes and home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_641665_0009	535

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	Légende 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. 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 ensure a resident was free from neglect by the licensee or staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The MLTC received a critical incident system (CIS) report.

The resident' assessment and care plan showed that they had a severe functional impairment on the right side, used a mobility device and required supervision for ambulation.

The PSW stated that they left the resident unsupervised during ambulation and they sustained a fall which caused an impairment on their left side. The resident was transferred to hospital for assessment and treatment and was diagnosed with a global impairment which caused a significant change in their health status.

The DOC acknowledged that the PSW did not provide the assistance required for safety which jeopardized the health, safety and well-being of the resident.

Sources: The critical incident report, resident’s plan of care and progress notes, interview with PSW, DOC and others. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) 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 are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A CIS report was received by the MLTC.

The CIS report and the resident’s progress notes indicated that the resident had a fall and was assessed by the RPN. The resident sustained an injury, but remained alert and oriented. The resident was administered a blood thinner medication daily, however the registered staff did not notify the physician that the resident had a fall with identified injuries. Approximately one hour later, the resident became unresponsive, was transferred to hospital and passed away.

The RPN verified that they did not contact the physician at the time of the fall; and stated in retrospect, they should have called the physician because the resident was administered a blood thinner medication.

Sources: The resident’s progress notes; interview with RPN and others. [s. 6. (4) (a)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care revised because care set out in the plan had not been effective, and different approaches were considered in the revision of the plan of care.

The resident had four falls that were documented on four separate dates at approximately the same time of day.

The Manager of Residents Safety (MRS) and Falls Lead acknowledged that the resident’s plan of care should have been revised and different approaches considered since all falls occurred around the same time of day.

Sources: The resident's post fall assessments, progress note, interview with MRS and others. [s. 6. (11) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other; and
-to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: 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:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident's plan of care was based on an interdisciplinary assessment of the resident’s communication abilities, including language.

The resident experienced a fall while ambulating without supervision. Their plan of care indicated they should have been supervised by staff while ambulating. After the incident, the resident started communicating with staff in their native language, and the registered staff called another staff to translate the resident's concerns. The translator communicated that the resident had an injury which required transfer to hospital for assessment and treatment.

The PSW and Resident Safety Manager stated that the resident understood some English, however the home did not have other communication tools/strategies readily available to support their language barrier.

Sources: The resident’s plan of care and progress notes, interview with PSW and others.
[s. 26. (3) 3.]

WN #4: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A CIS report was received by the MLTC.

The CIS report and the resident’s progress notes indicated that they had a fall. The next day after the incident, the resident complained of discomfort to specific areas of their body, and was transferred to hospital for assessment and treatment. The resident returned to the home two days later, with a diagnosed injury.

The CIS report was not submitted to the Director until five days after the injury was diagnosed; and the MLTC after hours pager was not contacted regarding the incident.

Sources: The critical incident report, resident’s progress notes, interview with DOC. [s. 107. (3)]

Issued on this 1st day of February, 2021

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VERON ASH (535)
Inspection No. / No de l'inspection :	2020_808535_0016
Log No. / No de registre :	001416-20, 003445-20, 004771-20, 007871-20, 007971-20, 008010-20, 009037-20, 014349-20, 014371-20, 022596-20, 023466-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 28, 2021
Licensee / Titulaire de permis :	The Kensington Health Centre 25 Brunswick Avenue, Toronto, ON, M5S-2L9
LTC Home / Foyer de SLD :	The Kensington Gardens 25 Brunswick Avenue, Toronto, ON, M5S-2L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	William O'Neill

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To The Kensington Health Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

-Educate all PSWs working on the same home unit about the importance of adhering to residents' plan of care related to supervision with mobility/ambulation.
-Document the education, including the date, participants and the staff member who provided the education.
-Perform weekly audits related to the identified PSW's work and two other random PSWs working the same shift on different units for a period of one month to ensure they adhere to assigned residents' plan of care related to mobility/ambulation.
-Document the result of each audit and all concerns with PSWs practice and actions taken if required, by the person conducting the audit.

Grounds / Motifs :

1. The licensee has failed to ensure a resident was free from neglect by the licensee or staff in the home.

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The DOC acknowledged that the PSW did not provide the assistance required for safety which jeopardized the health, safety and well-being of the resident.

Sources: The critical incident report, resident’s plan of care and progress notes, interview with PSW, DOC and others. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: As a result of the fall, the resident sustained a functional injury to their left side. There was actual harm to the resident.

Scope: This non-compliance was isolated since the incident was related to one resident.

Compliance History: In the past 36 months, the licensee was non-compliance with s. 19 (1) of the LTCHA, resulting in a compliance order (CO) being issued in report #2018_324535_0013 which was complied on March 26, 2019; and a Voluntary Plan of Compliance was issued in report #2018_370649_0002 on March 27, 2018. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 19, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of January, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Veron Ash

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