Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Toronto District**
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# Original Public Report

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| **Report Issue Date:** July 11, 2023 | |
| **Inspection Number:** 2023-1337-0004 | |
| **Inspection Type:**<br>Critical Incident System | |
| **Licensee:** The Kensington Health Centre | |
| **Long Term Care Home and City:** The Kensington Gardens, Toronto | |
| **Lead Inspector**<br>Fiona Wong (740849) | **Inspector Digital Signature**<br>Fiona Hoi Kwan Wong-Dip<br>Digitally signed by Fiona Hoi Kwan Wong-Dip<br>Date: 2023.07.12 11:49:57 -04'00' |
| **Additional Inspector(s)**<br>Britney Bartley (732787) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 21-22, 26-30, 2023 and July 4-5, 2023

The following intake(s) were inspected:

- Intake: #00004105 - related to plan of care.
- Intake: #00011726 - related to medication management.
- Intake: #00087718 and #00089596 - related to falls prevention and management.
- Intake: #00090063 - related to alleged neglect.

The following intake(s) were completed:

- Intake: #00018730 and #00019102 - related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the care of a resident collaborated with each other in processing changes to their medication orders.

**Rationale and Summary**
The Long-Term Care Home (LTCH) received an assessment report and recommendations for medication changes from an external provider. A receptionist received the documents and placed it on the nurse manager's desk. A Nurse Manager (NM) did not see the documents during their shift that day. Registered Practical Nurse (RPN) #107 was notified by the resident's family member that the resident should receive changes to their medication. RPN #107 did not receive the orders during their shift and endorsed the follow up to RPN #108 for the next day.

On the next day, RPN #108 did not work and the registered staff working did not follow up. The documents were resent to the LTCH, received by the receptionist, and placed it on the nurse manager's desk. The NM again did not see the fax during their shift that day.

On the third day, an Assistant Director of Care (ADOC) noticed the documents on the nurse manager's desk and brought it up to RPN #107. RPN #107 stated they did not receive the documents.

On the fourth day, RPN #108 noticed the original documents at the nursing station, which had not been processed and reported to their manager. The Nurse Practitioner (NP) was made aware the order was not processed when they attempted to evaluate the effectiveness of the medication change. The NP assessed the resident and determined that they should be sent to the hospital for closer monitoring.

Failure to collaborate in processing changes to the resident's medication orders delayed their treatment

to improve their symptoms.

**Sources**: Interviews with a receptionist, two RPNs, the NP, and the ADOC, the home's investigation notes, the resident's progress notes and Medication Administration Record (MAR), staff communication book, the home's "Order Medication" policy.

[740849]

## WRITTEN NOTIFICATION: Plan of Care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

**Rationale and Summary**
On a specified day, the resident was assessed by an NP due to specified symptoms experienced over a number of days. The NP ordered diagnostic testing.

An RPN and an ADOC confirmed that the specified diagnostic testing report was not found in the resident's chart.

The ADOC also acknowledged that a copy of the diagnostic testing requisition could not be found for this order, therefore confirmed the diagnostic testing was not processed for the resident.

Failure to process the resident's diagnostic testing order as specified in their plan of care delayed the process in identifying the cause of their condition and delayed necessary treatments.

**Sources**: Interviews with an RPN and an ADOC, the resident's clinical records.

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## WRITTEN NOTIFICATION: Pain Management

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The licensee has failed to comply with their pain management program when new pain was identified for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the pain management program provide communication and assessment methods for residents who are cognitively impaired.

Specifically, staff did not comply with the LTCH's pain management policy when the resident's pain was not documented and thoroughly assessed using the Pain Assessment Tool.

**Rationale and Summary**
The resident sustained an injury causing pain. The resident reported the pain to a Personal Support Worker (PSW). The pain was not documented in the resident's Point of Care (POC) record.

The PSW stated the pain was reported to RPN #111 immediately, but RPN #111 stated no staff reported to them that the resident was experiencing pain.

Another PSW reported the resident's pain to RPN #112. RPN #112 and an NP assessed the resident, but the Pain Assessment Tool was not completed.

The home's pain management policy directs staff to document pain in POC and report to Registered Nurse (RN)/RPN. Registered staff are directed to use the Pain Assessment Tool to assess the resident's pain once reported.

RPN #112 and an ADOC confirmed that the Pain Assessment Tool was not completed when new pain was identified for the resident, and it should have been done. An ADOC also acknowledged that the new pain was not documented in the resident's POC record, and it should have been done.

Failure to follow the home's pain management policy delayed the resident's pain management treatment and not identifying the severity of the resident's pain.

**Sources**: Interviews with a PSW, two RPNs, an NP, and an ADOC, the resident's clinical records, the home's "Pain Management Program" policy, CI report.

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## WRITTEN NOTIFICATION: Reports re Critical Incidents

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

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

**Rationale and Summary**
A Critical Incident (CI) was submitted to the Director for a fall resulting in injury for a resident. The resident sustained an unwitnessed fall and was sent to the hospital. In review of the resident clinical records indicates the home was notified of the resident's injury resulting in a significant change on the same day.

An ADOC acknowledged the home was aware of the significant change in the resident's health condition, and did not report to the Director until three days later.

**Sources**: Interview with an ADOC, CI Report, the resident's clinical records.

[732787]

## WRITTEN NOTIFICATION: Reports re Critical Incidents

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.

The licensee has failed to ensure that the Director was informed of a medication incident which resulted in a resident being taken to the hospital no later than one business day after the occurrence of the incident.

**Rationale and Summary**
A CI report was submitted to the Director regarding a medication incident for the resident. On a specified day, the LTCH realized that a prescription order for the resident was not processed for several days. The resident was later sent to the hospital for closer monitoring.

The CI report was submitted to the Director weeks after the LTCH was made aware of the incident.

An ADOC acknowledged that the incident was not submitted on time.

**Sources**: The home's investigation notes, CI Report, interview with an ADOC.

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