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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: November 17, 2023

Inspection Number: 2023-1337-0006

Inspection Type:
Critical Incident
Follow up

Licensee: The Kensington Health Centre

Long Term Care Home and City: The Kensington Gardens, Toronto

Lead Inspector	**Inspector Digital Signature**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2023.11.30 14:33:56 -05'00'

Additional Inspector(s)
Fiona Wong (740849)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 19-20, 23-25, 30-31, 2023 and November 1, 2023

The following intakes were inspected in the Critical Incident System (CIS) Inspection:
· Intake: #00091637 - [CIS:2852-000020-23] related to injury of unknown cause.
· Intake #00093214 - [CIS:2852-000024-23] and Intake #00094789 - [CIS:2852-000026-23] were related to a disease outbreak.
· Intake: #00096947 - [CIS:2852-000029-23] related to falls prevention and management.
· Intake: #00099051 - [CIS:2852-000034-23] related to unexpected death.

The following intake was inspected in the Follow-up Inspection:
· Intake: #00097440 related to medication administration.

The following intake was completed in the CIS Inspection:
· Intake: #00095293 - [CIS:2852-000027-23] related to an injury with a significant change in condition.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1337-0005 related to O. Reg. 246/22, s. 140 (1) inspected by Rajwinder Sehgal (741673)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the planned fall intervention was included in a resident's written plan of care.

Rationale and Summary
A post fall team review was conducted for the resident after a fall. Within the review, a fall intervention indicated to already be in place to prevent future falls and injuries.

In reviewing the resident's care plan, the fall intervention was added when the resident sustained a

second fall several months later.

Registered Practical Nurse (RPN) and Associate Director of Care (ADOC) both stated that the fall intervention should have been added to the resident's care plan before the first fall, since it had already been implemented.

Failure to update the resident's care plan increased the risk of staff not being aware of the fall interventions.

Sources: Resident's clinical records, interviews with RPN, ADOC and other staff.

[740849]

Date Remedy Implemented: September 7, 2023

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 the resident as specified in the plan.

Rationale and Summary
A resident was assessed at risk for falls. According to a post fall team review, the resident was recommended to be placed in an identified area of the home for monitoring to minimize falls and injuries.

The resident had an unwitnessed fall in a different area of the home and sustained an injury.

The RPN and ADOC both indicated that supervision and monitoring should have been provided to the resident. The ADOC acknowledged that the resident's plan of care was not followed.

Failure to provide supervision as specified in the resident's plan of care resulted in a fall with injuries.

Sources: resident's clinical records, interviews with RPN, RPN, ADOC and other staff.

[740849]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their care needs changed.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Director related to a resident's injuries of an unknown cause for which they were taken to the hospital for further assessment.

The resident's care plan indicated that they required specific staff assistance for transfers. The home's internal investigation notes and the resident's progress indicated that staff transferred the resident using a different technique upon receiving directions from the RPN.

The home's policy titled "Lifts and Transfers" indicated residents will be assessed for transfer needs upon admission, quarterly and with any condition change by completing the Safe Lift and Transfer Assessment.

The RPN acknowledged that they had recommended staff to use a different transfer technique before conducting the safe lift and transfer assessment for the resident.

Failure to reassess the resident when their care needs changed may lead to improper care being provided to the resident.

Sources: CIS, resident's clinical records, home's investigation notes, lift and transfer policy M2-750 last revised July 2018, interviews with RPN, and ADOC.

[741673]

WRITTEN NOTIFICATION: Skin and Wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)

The licensee has failed to ensure that a resident was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when they exhibited altered skin integrity.

Rationale and Summary
A resident sustained altered skin integrity. Their clinical records indicated that a skin and wound assessment was not completed.

RPN and ADOC both indicated that a skin and wound assessment was not completed for the resident.

Failure to complete a skin and wound assessment when the resident exhibited altered skin integrity put the resident at risk for not receiving the appropriate interventions.

Sources: resident's clinical records, interviews with RPN and ADOC.

[740849]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to comply with their nutritional care and hydration program after a resident had a change in health status.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the nutritional care and hydration program included implementation of policies and procedures relating to nutritional care and dietary services and hydration.

Specifically, staff did not comply with the licensee's policy "Eating Assistance, M2-480", last revised July 2018, when a dietitian referral was not sent after the resident had a change in health status.

Rationale and Summary
A resident experienced a change in health status during meal service.

The home's "Eating Assistance" policy directs staff to refer to the Registered Dietitian (RD) if a resident has swallowing difficulties or dysphagia further progresses.

RPN #104, RPN #105, the RD and Director of Care (DOC) confirmed that an RD referral was not sent after the resident had a change in health status, and should have been completed.

Failure to send a RD referral after a change in the health status increased the risk of re-occurrence if the root cause was not identified.

Sources: Interviews with RPN #104, RPN #105, RD and DOC, resident's clinical records, the home's "Eating Assistance" policy (M2-480, last revised July 2018).

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented. Specifically, Section 9.1, "the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program", including the four moments of hand hygiene.

Rationale and Summary
During an observation, the Personal Support Worker (PSW) exited the resident's room after fixing the resident's bed without performing hand hygiene. Later, the same PSW entered another resident's room and did not perform hand hygiene prior to applying gloves before the resident's transfer.

The home's policy titled "Hand Hygiene" directed all staff to clean their hands when entering/leaving before/after touching the resident or any object or furniture in the resident's environment.

The PSW acknowledged that they did not perform hand hygiene before initial resident's environment contact. The Infection Prevention and Control (IPAC) Lead indicated that staff were to perform hand hygiene before and after coming into contact with a resident or resident's environment. They acknowledged that the PSW did not implement appropriate hand hygiene practice.

Failure to perform hand hygiene before/after initial resident/resident environment placed the resident at increased risk for transmission of infection.

Sources: Observation, review of the Long-Term Care Homes (LTCH) policy Hand Hygiene M6-100 last revised March 2020, IPAC Standard for LTCH's last revised April 2022, interviews with PSW and IPAC Lead.

[741673]

WRITTEN NOTIFICATION: Reports Re Critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act using the CIS report.

Rationale and Summary
The home's north building resident home areas (RHA) two west and three east were declared in a confirmed outbreak on July 24, 2023, by the Toronto Public Health (TPH). A CIS report was submitted to the Director related to the confirmed outbreak on July 26, 2023, two days after it was declared.

The IPAC Lead was aware that the confirmed outbreak was required to be reported immediately and confirmed that the Director was not notified immediately.

There was no risk to residents when the confirmed outbreak was not reported immediately to the Ministry of Long-Term Care (MLTC).

Sources: CIS report, and interview with IPAC Lead.

[741673]

COMPLIANCE ORDER CO #001 Dining and Snack Service

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Conduct audits for a period of two weeks, following the service of this order, for three random residents who are at high safety risk during meals to ensure their plan of is followed.

2) Maintain a documented record of audits conducted to include, but not limited to: dates of the audit completion, residents audited, results of each audit and corrective actions taken in response to the audits.

Grounds
The licensee has failed to ensure that the home had a dining service that included personal assistance required to safely eat as comfortably as possible.

Rationale and Summary
A resident was assessed to require assistance during meals due to an identified health condition.

The resident's plan of care stated that they required specific assistance during meals. The RD recommended independent feeding and staff to provide supervision for safety.

The resident experienced a change in health condition during the meal service, which resulted in their passing.

Based on the home's investigation notes, the PSW advised that when a second meal serving was provided to the resident they failed to provide supervision or eating assistance.

The DOC acknowledged that based on the home's investigation, the PSW did not provide eating assistance or supervision as indicated in their plan of care.

Failure to provide eating assistance and supervision resulted in harm to the resident.

Sources: Resident's, the home's investigation notes, interviews with RD, DOC and other staff.

[740849]

This order must be complied with by December 8, 2023

COMPLIANCE ORDER CO #002 Pain Management

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Ensure all registered staff assigned to home's south building on two RHAs are re-educated on the home's pain management policy, specific to the completion of pain assessments, when a resident exhibits newly identified pain.
2) Conduct audits for a period of four weeks, following the service of this order, on random residents who are experiencing pain to ensure residents are assessed appropriately using the home's pain assessment tool.
3) Maintain a record of audits, including the dates, who conducted audits, staff and residents audited, results of audits and actions taken in response to the audit findings.

Grounds
The licensee has failed to comply with their pain management program when new pain was identified for resident #001 and resident #003.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the pain management program included implementation of policies and procedures relating to communication and assessment methods for residents who are cognitively impaired.

Specifically, staff did not comply with the LTCH's pain management policy when resident #001 and resident #003 were not assessed using the Pain Assessment Tool (PAT).

Rationale and Summary
The home's pain management policy directed nurses to conduct a pain assessment using the PAT when a resident stated they had pain, or when pain was present. Specifically for cognitively impaired residents, the Pain Assessment in Advanced Dementia (PAINAD) Scale should be used.

i) PSW #121 reported to RPN #123 when they discovered resident #001 was in pain, however RPN #123 did not complete a pain assessment.

Two days later, during the provision of care, resident #001 was discovered with altered skin integrity, and complained of pain to a specified body part. PSW #120 reported these injuries to RPN #122. RPN #122 attended the resident, however failed to complete a pain assessment using the PAT. Record review indicated that resident #001 continued to demonstrate signs of pain on multiple dates, however, pain assessments using the PAT were not completed by registered staff.

RPN #122 acknowledged that the resident was in pain and that a pain assessment was not completed.

The ADOC acknowledged that registered staff failed to complete pain assessments when the resident was experiencing pain.

Failure to complete pain assessments on the resident increased the risk of not identifying the severity of the resident's pain.

Sources: CIS, home's Pain Management policy M2-840 last reviewed July 2018, resident #001's progress notes, assessments, and interviews with PSW #120, #121, RPN #122, #123, and ADOC.

[741673]

ii) Resident #003 was assessed with cognitive impairment.

Resident #003 was observed in pain and guarding a specified body part when touched. They were also noted with an injury to a specified body part.

The RPN and ADOC both acknowledged that the PAINAD Scale was not completed for resident #003 when they were observed in pain.

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

Sources: Interviews with RPN and ADOC, resident #003's clinical records, the home's pain management program policy (M2-840, last revised July 2018).

[740849]

This order must be complied with by February 12, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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