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

Report Issue Date: March 20, 2024

Inspection Number: 2024-1337-0002

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**
Michael Chan (000708)	Michael K Chan Digitally signed by Michael K Chan Date: 2024.03.27 12:06:13 -04'00'

Additional Inspector(s)
Yannis Wong (000707)
Betty-Jo Horan (000824) was present during this inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26, 27, 29, 2024 and March 1, 4-7, 14 (off-site) 2024

This inspection was conducted concurrently with inspection #2024-1337-0003

The following intakes were inspected:

- Intake: #00102063 - Follow-up #: 1 - CO #002, 2023-1337-0006; Pain Management, O. Reg. 246/22 - s. 57 (1) 1. CDD February 12, 2024.
- Intake: #00106639 - [CI: #2852-000003-24] - Fall resulting in injury

The following intakes were completed:

- Intake: #00110138 - [CI: #2852-000025-24] - Fall resulting in injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1337-0006 related to O. Reg. 246/22, s. 57 (1) 1. inspected by Yannis Wong (000707)

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

Infection Prevention and Control
Staffing, Training and Care Standards
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 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure the written plan of care for a resident set out clear directions for transfers and toileting to staff and others who provided direct care to the resident.

Rationale and Summary
A resident sustained an injury, and their care plan was updated. During an observation, a PCA (Personal Care Attendant) performed a transfer the resident with an assistive device that was not in accordance with their care plan. The PCA also stated the resident was transferred earlier that day, however, it did not align with the resident's care plan.

The PCA stated they followed the directions from the PCA assignment sheet, which indicated a different level of transfer from the resident's care plan. The staff reviewed the PCA assignment sheet and not the electronic Kardex at the start of their shift and acknowledged the directions were inconsistent. They acknowledged the resident was improperly transferred and that they should have used the assistive device with another staff for the resident's transfer.

The physiotherapist (PT) conducted an assessment for the resident on the same day as the inspector's observation that confirmed the resident's transfer status as per the care plan. An Associate Director of Care (ADOC) stated staff were expected to review the Kardex and not the staff assignment sheet, and acknowledged the discrepancy provided unclear direction to the staff.

Failure to ensure the plan of care for a resident set out clear directions to staff, put the resident at risk of injury during transfer.

Sources: Observations; resident's clinical records; PCA assignment sheet; interview with PCA, PT, and ADOC.

[000707]

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)
Plan of care
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.

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

Rationale and Summary
A resident sustained a fall and was later transferred to hospital and diagnosed with an injury. The resident was at risk of falls and had a falls prevention intervention in their plan of care that was not applied by staff prior to the fall.

The PCA acknowledged they did not apply the falls prevention intervention to the resident. An ADOC confirmed the PCA did not follow the resident's plan of care.

Failure to apply the falls prevention intervention put the resident at risk for injury.

Sources: Resident's clinical records; home's investigation notes; interviews with PCA and ADOC.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (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 (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

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

Rationale and Summary
A resident was transferred to the hospital and diagnosed with an injury. The home became aware of the resident's injury on the same day.

A critical incident system (CIS) report for this incident was not submitted to the Ministry of Long-Term Care (MLTC) until three days later. An ADOC confirmed the incident was not reported to the Director in a timely manner.

Failure to report the incident that causes an injury to the resident where they were taken to a hospital and that resulted in a significant change in the resident's health condition within one business day could delay follow up actions by the Director.

Sources: CI #2852-000003-24; resident's clinical records; interview with ADOC.

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