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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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 20, 2024	
Inspection Number: 2024-1337-0003	
Inspection Type: Complaint	
Licensee: The Kensington Health Centre	
Long Term Care Home and City: The Kensington Gardens, Toronto	
Lead Inspector Michael Chan (000708)	**Inspector Digital Signature** Michael K Chan Digitally signed by Michael K Chan Date: 2024.03.27 12:06:55 -04'00'
Additional Inspector(s) Inspector 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, 2024

The inspection occurred offsite on the following date(s): March 14, 2024

This inspection was conducted concurrently with inspection #2024-1337-0002

The following intake(s) were inspected:

- Intake: #00102732 - Complaint related to emotional abuse of a resident by staff

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director upon receipt of the complaint.

Rational and Summary
The home received multiple email complaints between a specified timeframe related to the care of a resident. These complaints were not forwarded to the Ministry of Long-Term Care (MLTC) as per the reporting guidelines.

Management at the home acknowledged the complaints should have been forwarded to MLTC.

Failure of the home to immediately inform the Director can lead to the inability of the Ministry to be informed of any written complaint that the home receives concerning the care of a resident or the operation of the home and a delay in follow-up actions.

Source: Home's investigation notes, interview with the home's management. [000708]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality regardless of their age and disability.

Rational and Summary

A meeting was held with the resident, the resident's family, and the home's staff. Staff at the home did not treat the resident with respect during the meeting. Staff collectively raised their voices, yelled, made inappropriate gestures, and left the meeting before it was concluded The home indicated the staff demonstrated unprofessional behaviour and were insubordinate in the meeting.

Management at the home confirmed that during the meeting with the resident and the home, the staff were disrespectful and unprofessional and did not treat the resident with courtesy and respect.

The resident's right to be treated with courtesy and respect was not maintained during a meeting with the home's staff.

Source: Home's investigation notes, interview with the home's management. [000708]