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: July 19, 2024	
Inspection Number: 2024-1337-0005	
Inspection Type: Complaint	
Licensee: The Kensington Health Centre	
Long Term Care Home and City: The Kensington Gardens, Toronto	
Lead Inspector Chinonye Nwankpa (000715)	**Inspector Digital Signature** Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2024.08.07 09:54:05 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4- 5, 7, 10- 14, 20, 21, 24-25, 2024

The following intake(s) were inspected during this complaint inspection:
- Intake: #00111584 – Related to alleged emotional abuse/improper transferring.
- Intake: #00116179 – Related to Plan of care, Responsive behaviours, Behaviours and altercations

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Admission, Absences and Discharge

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)

Plan of care

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,

(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.

The licensee has failed to ensure that the staff and others involved in the different aspects of a resident's care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

Rationale and Summary

When a referral was made to the Behaviour Support Team (BST) regarding a resident's specific responsive behaviours, the BST made specific responsive behaviour recommendations.

The Associate Director of Care (ADOC) confirmed that the above mentioned recommendations made by the BST had been implemented months prior to the referral. Furthermore, ADOC stated the recommendations BST made were not communicated to the staff and as a result were ineffective. The BST confirmed that they did not perform the behaviour huddle and that they did not involve the care staff in the development and implementation of the resident's responsive behaviour

interventions following receipt of the referral.

There was increased risk of worsening responsive behaviours when the staff failed to collaborate in the development and implementation of the resident's plan of care.

Sources: Resident's clinical records, Responsive Behaviours Policy M2-965 Last revised August 2017; Interviews with the BST and ADOC. [000715]

WRITTEN NOTIFICATION: Complaints Procedure- Licensee

NC #002 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 they immediately forwarded to the Director written complaints they received concerning the care of a resident.

Rationale and Summary
The home received emails from a resident's family members regarding care concerns of the resident.

The Director of Care (DOC) acknowledged that the emailed complaints received were not reported to the Director.

Sources: Email Complaint Records; Interview with the DOC. [000715]

WRITTEN NOTIFICATION: Communication and Response System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen by staff at all times.

Rationale and Summary
The home's investigation notes showed that when a resident rang the call bell for assistance, the call bell was unanswered for a period of time.

An observation revealed that when the call bell was rung, the communication and response system display monitor was not visible in certain areas on the home area.

A Personal Care Attendant (PCA) shared that they did not see the resident's call bell on the display monitor because it was not visible from where they were when the call bell was rung. A Registered Practical Nurse (RPN) confirmed that the display monitor was only visible when right in front of it.

The DOC acknowledged that the call bell display monitor was not visible in certain locations on the home area, and that the staff relied on the display monitor to be alerted when residents rang the call bell for assistance.

When the communication and response system was not easily seen by staff there

was an increased risk of harm to the resident as there was a delayed response to their call bell when they needed assistance.

Sources: Observations; Call Bell Report, the home's investigation notes; Interviews with the PCA, RPN and DOC. [000715]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, the behavioural triggers for the resident were identified.

Rationale and Summary
A resident exhibited specific responsive behaviours over a period of time, however their clinical records showed that the triggers were not identified for these behaviours.

The DOC and ADOC both acknowledged that the behaviour triggers were not identified when the resident exhibited responsive behaviours.

Failing to identify the resident's behaviour triggers increased the risk of poor responsive behaviour mitigation strategies which could result in the continuation or worsening of the resident's responsive behaviours.

Sources: Resident's clinical records, Responsive Behaviours Policy M2-965 Last revised August 2017; Interviews with the BST, ADOC and DOC. [000715]