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
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Public Report

Report Issue Date: June 3, 2025

Inspection Number: 2025-1337-0003

Inspection Type:
Complaint
Critical Incident

Licensee: The Kensington Health Centre

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 5-9, 13-16, 22-23, 26-30, and June 3, 2025
The inspection occurred offsite on the following dates: May 15, 23, 26-30, and June 2-3, 2025

The following intakes were inspected in this complaint inspection:
Intake #00140332 related to Infection Prevention and Control (IPAC) and resident care concerns.
Intake #00140764 related to skin and wound care concerns.
Intakes #00142021 and #00147452 related to multiple care concerns.

The following intakes were inspected in this Critical Incident System (CIS) inspection:
Intake: #00133258 (CIS #2852-000203-24/2852-000202-24) related to allegations of improper care and neglect.
Intake #00137535 (CIS #2852-000012-25) related to injury of unknown cause.
Intake #00138227 (CIS #2852-000017-25/2852-000019-25) related to allegations of improper care.
Intakes #00139160 (CIS #2852-000026-25) and #00139438 (CIS #2852-000030-25) related to resident to resident abuse.

Intake #00140555 (CIS #2852-000033-25) related to allegations of neglect and improper care.
Intake #00140645 (CIS #2852-000034-25) related to fall prevention and management.
Intake #00140870 (CIS #2852-000036-25) related to allegations of improper care.
Intake #00142592 (CIS #2852-000056-25) related to medication administration.
Intakes #00142641 (CIS #2852-000057-25), #00142663 (CIS #2852-000059-25), and #00142921 (CIS #2852-000060-25) related to improper care.
Intake #00143514 (CIS #2852-000065-25) related to allegations of neglect.
Intake #00144038 (CIS #2852-000073-25) related to allegations of improper skin and wound care.
Intake #00146952 (CIS #2852-000096-25) related to allegations of improper care.

The following intake was completed in this CIS inspection:
Intake #00141864 (CIS #2852-000049-25) was related to falls prevention and management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
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 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident's substitute decision-maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

i) The resident's SDM was not notified of the resident's test results, and was acknowledged by the Assistant Director of Care (ADOC).

Sources: Review of Critical Incident (CI) Report and resident's progress notes; and interview with the ADOC.

ii) The registered staff acknowledged they did not inform the resident's SDM of the change in treatment by the physician.

Sources: Review of CI Report and resident's progress notes; and interview with the staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the resident was reassessed and their plan of care reviewed and revised when the resident's continence care needs changed and an intervention was no longer necessary.

The resident was readmitted to the home from hospital and no longer required an intervention.

The resident's care plan was not updated and revised when the resident experienced a change in continence status.

Sources: Resident's clinical records; and interviews with Continence Lead and Director of Professional Practice (DPP).

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) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the care set out in their nutrition care plans had not been effective.

The resident had been refusing a specific texture diet. The resident's care plan and diet order indicated they were to be provided this texture diet even though they had been refusing this diet type for multiple months.

Director of Clinical Services (DOC) and DPP both indicated that the care set out in the resident's plan of care had not been effective and their care should have been reviewed and revised when the resident continued to refuse the specific texture diet.

Sources: Resident's clinical records, and interviews with DOC and DPP.

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that resident was protected from sexual abuse by another resident. Two staff observed one resident touching another resident inappropriately.

Section 2(1) of Ontario Regulation 246/22 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Sources: Both residents' clinical records, interview with staff.

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE - LICENSEE

NC #005 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.

i) The licensee has failed to immediately forward to the Director a written complaint that they received alleging improper care of the resident.

An email compliant alleging improper care was sent to the home on a specified date. The DPP acknowledged that the complaint was not forwarded to the Director immediately.

Sources: CI Report; and interview with DPP.

ii) The licensee has failed to immediately forward to the Director any written complaint that it received concerning the care of the resident for multiple incidents.

Four written complaints were submitted to the home concerning the care of a resident that were not forwarded to the Director.

The DOC and DPP both indicated four written complaints were not forwarded to the Director.

Sources: Home's investigation notes and correspondence; and interviews with DOC and DPP.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

i) The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper treatment or care had occurred to two residents that resulted in a risk of harm to the residents were immediately reported to the Director.

The ADOC acknowledged that the Director was not immediately notified of two incidents of improper or incompetent treatment or care that occurred.

Sources: CI report, and interview with ADOC.

ii) The Director was not notified immediately regarding an incident of improper care of the resident by a staff which resulted in harm or a risk of harm to the resident.

The DPP acknowledged that the licensee did not notify the Director of the incident.

Sources: CI report and interview with DPP.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure an incident of physical altercation that had occurred between two residents was immediately reported.

Sources: Resident's clinical records, interview with staff, CI report.

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #008 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 resident's call bell was easily accessible.

The home submitted to the Director a CI regarding an injury the resident sustained. The call bell was not accessible to them at the time of the incident, which was acknowledged by staff.

Sources: Review of CI report, resident's care plan and progress notes; and interview with staff.

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the home's falls prevention and management program was evaluated and updated at least annually for 2023 and 2024.

Sources: Interview with the DPP.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that post fall assessments were conducted when a resident had two falls on the same date, which was acknowledged by staff

Sources: Review of CI report, resident's progress notes and assessments; and interviews with staff.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident who exhibited altered skin integrity received (i) a skin assessment, (ii) immediate treatment and interventions to promote healing, and prevent infection and (iv) weekly assessments by the registered staff.

The resident had altered skin integrity when they were admitted. Additionally, a registered staff was informed of the altered skin integrity at a later date. Assessments of the altered skin integrity were not conducted on admission and on

notification of the altered skin integrity. Immediate treatment and interventions were not implemented to manage the altered skin integrity, and weekly assessments were not completed since admission. A staff indicated that the resident's altered skin integrity had worsened and increased in size during that month.

Sources: Review of resident's clinical records and interviews staff.

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee has failed to ensure that a resident who was incontinent, received an assessment using a clinically appropriate assessment instrument specifically designed for assessment of incontinence, when the resident returned from the hospital without a previous intervention.

The Continence Lead and DPP both indicated that a continence assessment should have been completed to address the resident's change in continence status upon return from hospital without an intervention, and it was not done.

Sources: Resident's clinical records, Home's Continence Care and Bowel Management policy (revised Nov 2012); and interviews with Continence Lead and DPP.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, the Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) was completed during the evening shift on one date and all shifts on three dates. Furthermore; results of BSO-DOS was not documented on the resident's clinical records as indicated in the home's Responsive Behaviour Policy .

Sources: Resident's clinical records, Responsive Behaviour Policy (revised Aug 2017) and interview with BSO Lead.

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed

incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of the witnessed incident of sexual abuse of the resident by another resident. The incident was reported to the police the following day.

Sources: Home's investigation notes and interview with staff.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1)
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. The response provided to a person who made a complaint shall include,
i. the Ministry’s toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under

the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that two written and one verbal complaints made to the home, concerning the nutrition and continence care of a resident and operation of the home were immediately investigated, and responses were provided to the complainant within 10 business days of receipt of the complaint.

The DOC and DPP both indicated that a response was not provided to the complainant within 10 business days upon receipt of the complaint.

Sources: Home's investigation notes and correspondence; and interviews with DOC and DPP.

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that resident's topical medication was stored in an area that was secured and locked.

Observations on two dates, revealed discontinued topical medication at the resident's bedside table. A registered staff acknowledged that the topical medication was to be stored with the discontinued medications and not at the resident's bedside table.

Sources: Resident's room observations; review of resident's Treatment Administration Record; and interview with staff.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that drugs were administered to a resident which had been prescribed for the resident.

A registered nurse administered medications to a resident that were ordered for another resident. Later that day, the resident's condition deteriorated and required transfer to the hospital.

Sources: Resident's clinical record, home's investigation notes, medication incident report.

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident involving a resident that resulted in their hospitalization was immediately reported to the Director of Nursing and Personal Care and the resident's attending physician.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home's medication incident policy related to incident reporting and documentation was complied with. The home's Medication Incidents policy indicated any medication incident will be reported immediately to the Director of Nursing and Personal Care and the resident's attending physician. This policy was not followed during medication incident involving the resident.

A registered nurse had administered the incorrect medications to a resident. The Director of Nursing and Personal Care and the resident's attending physician were not immediately notified of this incident.

Sources: Resident's clinical record, Medication Incidents Policy (revised 2017), the home's investigation notes, and interviews with the home's staff and management.

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 6 (4) (a) [FLTCA, 2021, s. 155 (1) (b)]:
The Licensee shall prepare, submit, and implement a plan to ensure that the registered staff collaborates with the physician immediately when residents have a change in health status. The plan shall include but is not limited to:

1) Develop and implement a notification process to ensure physician(s) are notified immediately of a resident's change in health status.

2) The person(s) responsible for implementing an action plan of the notification process (including target date).

3) Document training of registered staff of the notification process, who will be responsible for the training and completion date.

Please submit the written plan for achieving compliance for Inspection #2025-1337-0003 by June 17, 2025.

Please ensure that the submitted written plan does not contain any Personal Information (PI)/Personal Health Information (PHI).

This plan shall be implemented by the compliance due date: August 15, 2025

Please submit the written plan for achieving compliance for inspection #2025-1337-0003 by August 15, 2025.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that registered staff and others involved in the different aspects of care of four residents collaborated with the physician in the assessment of the residents.

i) The resident's diagnostic imaging report indicated an abnormal finding. A registered nurse received the result and failed to notify the physician of the abnormal finding. The DOC confirmed that the registered nurse should have communicated this assessment to the physician.

Failure to notify the physician led to a delay in assessment and action by the home to respond to the abnormal diagnostic imaging results.

Sources: Resident's clinical records; and interview with DOC.

ii) A resident had a change in health status and exhibited new symptoms. A registered nurse assessed the resident and failed to immediately notify the physician. The physician became aware of the resident's condition hours later and the resident had deteriorated in condition. An ADOC confirmed that the registered nurse should have called the physician immediately to notify them of their assessment of the resident.

Failure to immediately notify the physician of a change in health status led to the delayed transfer to the hospital and medical treatment of the resident.

Sources: Review of resident's clinical records, and interviews with staff.

iii) A resident had a change in health status and deteriorated an hour later. A registered nurse assessed the resident and acknowledged that the resident's had a change in status, did not notify the physician, and endorsed their assessment to the evening RPN (Registered Practical Nurse). The evening RPN re-assessed the resident an hour later and their health status deteriorated with signs and symptoms of a medical condition. They notified the family first which directed them to call the physician. The resident was transferred to hospital and diagnosed with a medical condition and subsequently passed away, a few days later.

The Physician acknowledged that there was a delay in treatment and transfer to hospital when they were not notified immediately.

Failure of the registered staff to notify the physician immediately negatively impacted the resident as it delayed any interventions and treatment to manage their change in health status and delayed their transfer to hospital.

Sources: Review of CI report and the resident's progress notes; and interviews with staff.

iv) A resident had two falls on the same day, which resulted in a change in their health status. The physician was notified multiple days later, of the resident's fall incidents and change in status, which led to the resident's transfer to hospital and diagnosed with an injury.

The resident was negatively impacted when the physician was not notified of the resident's two falls and change in status timely, as it delayed treatment and transfer to hospital to manage the resident's injury.

Sources: Review of CI report and resident's progress notes.

This order must be complied with by August 15, 2025

COMPLIANCE ORDER CO #002 PLAN OF CARE

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Review the resident's plan of care with an identified staff to ensure that they are aware of the contents of the plan of care. This review shall be conducted by a member of the management team.
2) Maintain the record of this review containing the name of staff who conducted the review and the dates that the review was completed.
3) Provide education to the identified staff on how to provide care to residents receiving oxygen including the risks associated with removing the oxygen during care.
4) Maintain a record of the education provided including the date and time, contents and who provided the education.
5) Retain all records until the Ministry of Long-Term Care (MLTC) has deemed this order has been complied.

Grounds

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

i) A resident had a treatment order to cover their altered skin integrity with specific dressings. On a specified date, it was discovered that their altered skin integrity was covered a different dressing. A registered staff indicated that the the treatment order was to be followed as per the plan of care.

The resident was at risk of delayed healing of their altered skin integrity when treatment orders were not followed.

Sources: Review of the resident's clinical physician orders, Medication Administration Record (MAR) and progress notes; and interview with staff.

ii) On a specified date, the resident was receiving a specific therapy; a Personal Care Attendant (PCA) removed the therapy to provide care and after several minutes, the resident experienced respiratory distress. The resident was receiving a specific therapy on that day and had an order for the therapy as needed in their plan of care.

The PCA stated that they removed the therapy from the resident without consulting with the registered staff or being aware of its need. Removing the therapy harmed the resident, resulting in respiratory distress and hospitalization.

Sources: Resident's clinical records, CI report and interview with the PCA.

This order must be complied with by July 15, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Order #001 of 2022-1337-0001, FLTCA, 2021, s. 6 (7)

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services

(PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.