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

Public Report

Report Issue Date: September 25, 2025

Inspection Number: 2025-1337-0005

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Kensington Health Centre

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 28-31, 2025, August 1, 6-8, 11-15, 19, 2025 and September 15-17, 19, 22, 24, 2025
The inspection occurred offsite on the following date(s): August 18, 2025 and September 23, 2025

The following Follow-Up intake(s) were inspected:
· Intake: #00136790 was a Follow-Up to a Compliance Order (CO) for Infection Prevention and Control (IPAC).

The following Critical Incident (CI) intake(s) were inspected:
· Intakes: #00143777 / CI #2852-000066-25; #00148436 / CI #2852-000117-25; and #00149998 / CI #2852-000120-25 were related to communicable disease outbreaks.
· Intakes: #00144003 /CI #2852-000072-25; #00146389 / CI #2852-000088-25; #00146891 / CI #2852-000093-25 were related to falls prevention and management.
· Intake: #00145040 / CI #2852-000080-25 was related to medication management and resident care and services.
· Intake: #00145711 / CI #2852-000084-25 was related to an unexpected death.
· Intake: #00147091 / CI #2852-000099-25 was related to prevention of abuse and neglect.

The following Complaint intake(s) was inspected:
· Intake: #00150207 was related to multiple care areas.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1337-0007 related to O. Reg. 246/22, s. 102 (2) (b)

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

Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident was documented.

Over a specific time period, staff did not document a procedure for the resident following an incident.

Sources: Resident's clinical records; interviews with a Registered Practical Nurse (RPN), Registered Nurse (RN), and Assistant Director of Care (ADOC); Fall Prevention and Management Program Policy.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that staff complied with the home's falls prevention and management program of initiating a procedure after a resident's fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's policy under the home's falls program indicated a procedure was to be initiated by the registered nursing staff after a fall. An RPN acknowledged that the procedure was not initiated.

Sources: Home's policy Falls Prevention and Management Program; Resident's clinical records; Interview with an RPN.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that the nutritional care and hydration program included the implementation of policies and procedures related to nutritonal care and dietary services and hydration when a Personal Care Assistant (PCA) provided

assistance to a resident.

Specifically, the PCA did not comply with a policy which was part of the home's nutritional care and hydration program. The policy indicated how staff should be positioned when providing a type of assistance.

On a specific date, the PCA was providing this type of assistance to the resident and indicated they were not in the position as per policy.

Sources: Resident's clinical records, home's policy Audit - Meal Service and Dining Room Form, interview with the PCA.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed of an unexpected resident death. The resident died following an incident, and the the Critical Incident System (CIS) report was submitted late. The late reporting was acknowledged by the Director of Professional Practice/IPAC lead (DPP/IPAC lead).

Sources: CIS report, resident's clinical records, interview with the DPP/IPAC lead.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 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 an incident that caused an injury to a resident for which the resident was transferred to another facility and that resulted in a significant change in the resident's health condition.

The resident was transferred to another facility on a specific date and diagnosed with a signficant change in their health condition. The home became aware of the resident's injury the next day.

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

Sources: CIS report; resident's clinical records; interview with the RN.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5).

The licensee has failed to ensure that when critical incidents for a resident resulted in

injuries and transfer to another facility, and that the licensee was unable to determine whether the injury resulted in a significant change in the resident's health condition, that the Director was informed of the incident no later than three business days after the occurrence of each incident.

MLTC received a complaint related to the resident and their multiple incidents with subsequent injuries, and the home's management of the resident's incidents.

The resident experienced multiple incidents in a specific year that resulted in transfer to another facility and changes in their condition. The home did not report the resident's critical incidents to the MLTC at the time when the home became aware of their diagnosis.

Sources: CIS reports; interview with DPP/IPAC lead.

COMPLIANCE ORDER CO #001 Plan of Care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Create a case study scenario of this incident including a review of a specific resident records.
2. Conduct an in-person review of the case study with Registered Dietitians (RDs) #136 and #138.
3. In the review:
a. Discuss and document the steps that an RD should take in response to case study mentioned in step 1 including but not limited to a reflection of actions taken, actions that could have been taken but were not and actions taken to prevent a re-occurence, and any other recommendations.
b. Discuss and document the steps that an RD should take if they receive information from staff about a specific procedure that includes but is not limited to communication

with front-line staff.
4. Maintain the records of the above discussions including the content of the case study, content of the review, sample care plan, date of the review, name of staff who provided the review, and staff signed attendance.

Grounds

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

The resident's plan of care indicated their status and goal related to a specific activity of daily living (ADL).

(i) On a specific date, RD #136 assessed the resident and documented that an intervention was required for a specific sign, and the resident's risk for a medical emergency related to an ADL. RD #136 acknowledged the resident's care plan should have provided clear directions to staff and others related to this risk factor.

(ii) On another date, RD #138 assessed the resident and observed during a specific ADL. RD #138 acknowledged that the resident's care plan should have been updated to provide clear directions to staff and others assisting with this ADL.

(iii) On a later date, a PCA assisted the resident with a specific ADL and indicated they were not aware of multiple details from the RDs' assessments related to providing this type of assistance. The PCA reported the specific sign that started while providing assistance to the resident and an Agency RPN (A-RPN) indicated this was a normal response for the resident. The sign progressed and the resident experienced a significant change in heatlh status.

Sources: Resident's clinical records, interviews with the PCA, RDs #136, #138, A-RPN and an RPN.

This order must be complied with by November 10, 2025

COMPLIANCE ORDER CO #002 Plan of Care

NC #008 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)]:
For incident related to resident in Scenario 1:
1. Create a case study scenario of this incident.
2. Conduct an in-person review of the case study with the Environmental Supervisor including but not limited to communicating with registered staff before initiating resident contact, actions to prevent re-occurrence, and any other recommendations.
3. Maintain the records of the above discussions including the content of the case study, content of the review, date of the review, name of staff who provided the review, and staff signed attendance.

For incident related to resident in Scenario 2:
1. Create a case study scenario of this incident including signs and symptoms of a specific medical condition.
2. Conduct an in-person review of the case study with the PCA including but not limited to safe positioning for a resident who is potentially experiencing a medical emergency and communicating with registered staff before acting against a resident’s care plan, actions to prevent re-occurrence, and any other recommendations.
3. Maintain records of the above discussions including the content of the case study, content of the review, date of the review, name of staff who provided the review, and staff signed attendance.

Grounds

The licensee failed to ensure that the care set out in the plan of care related to specific ADLs for two residents were provided as specified in the plan.

Scenario 1)A resident's plan of care provided specific direction to staff on methods to be used when assisting the resident with a specific ADL.

An Environmental Supervisor went to a resident's room and communicated directly to the resident asking them to move from one area to another. An incident occurred that

led to the resident being transferred to another facility where they were diagnosed with a change in health status.

Sources: Resident's clinical records; and interviews with Environmental Supervisor and ADOCs.

Scenario 2)A resident's plan of care indicated they required assistance with a specific ADL. A care intervention indicated the resident was to be kept in a certain position for a specific duration after the ADL ended.

(i) A PCA assisted the resident with the ADL. They acknowledged the resident began showing a specific sign and indicated they changed the resident's position that contradicted with the resident's plan of care.

(ii) A PCA observed the resident showing the specific sign and in a certain position. The PCA explained to another PCA that the resident needed to be returned to their initial position because they were experiencing a medical emergency.

The resident's plan of care was not followed when their position was changed within a prohibited time period.

The resident experienced a significant change in health status.

Sources: Resident's clinical records, home's investigation notes, interviews with two PCAs and former ADOC.

This order must be complied with by November 10, 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 $3300.00, 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:

A non-compliance under FLTCA, s. 6(7) was issued as a CO in #2025-1337-0003 on June 3, 2025, and in #2022-1337-0001 on June 17, 2022.

This is the third 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.

COMPLIANCE ORDER CO #003 Duty to Protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall
1. Create a case study scenario of this incident of neglect.
2. Conduct an in-person review of the case study with all PCAs, RPNs, and RNs in a specific resident home area (RHA) including but not limited to actions taken by staff to

prevent re-occurrence, and any other recommendations.
3. Maintain records of the above discussions including the content of the case study, content of the review, date of the review, names of staff who provided the review, and staff signed attendance.

Grounds

The licensee has failed to ensure a resident was not neglected by staff.

O. Reg. 246/22, section seven defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was showing a specific sign while being assisted with an ADL by a PCA. The situation progressed to a medical emergency, that was recognized by the A-RPN, and resulted in a significant change of health status for the resident.

During this incident, multiple staff neglected to provide care and assistance to the resident, jeopardizing their health and safety.

The DPP/IPAC lead indicated the expectation of the A-RPN in responding to the incident was to perform specific procedures, call the physician or NP, and none of these actions were performed. The failure to take any action resulted in a significant change in health status for the resident.

Sources: Resident's clinical records, home's investigation notes, interviews with a PCA, A-RPN, former ADOC and DPP/IPAC lead.

This order must be complied with by November 10, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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:

A non-compliance under FLTCA, s. 24 (1) was issued as a CO in #2024-1337-0004 on July, 19 2024.

This is the first 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.

COMPLIANCE ORDER CO #004 Emergency Plans

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
vi. medical emergencies,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Develop an in-depth analysis of the home's response to this medical emergency involving a resident. This analysis should include:
a. What actions staff took when responding to the emergency
b. What actions that could have been taken in response
c. How the home's existing process impacted the response in this medical emergency
2. As a result of this review develop and implement a medical emergency plan/protocol for responding to a medical emergency specifically related to this type of medical emergency.
3. The emergency plan/protocol should include clear lines of authority, a communication plan, and specific staff roles and responsibilities for responding to a medical emergency.
4. The plan/protocol should include staff access to availability of essential supplies and equipment in an emergency response.
5. Create a training schedule that will ensure all front-line staff (PCAs, RPNs, RNs) in the home will be trained on the home's medical emergency plan by a specific date.
6. Keep a written record of steps 1 through 5 until this order has been complied.

Grounds

The licensee has failed to ensure that emergency plans provided for dealing with emergencies, including but not limited to medical emergencies, were in place when a resident experienced a change in health status.

The O. Reg. 246/22, section 268 (15) defines an emergency as an urgent or pressing situation or condition presenting an imminent threat to the health or well-being of residents and others attending the home that requires immediate action to ensure the safety of persons in the home.

While being assisted with an ADL by a PCA, a resident began show a specific sign. The PCA reported the specific sign the A-RPN who replied that the specific sign was normal for the resident.

The resident continued to show the specific sign. The A-RPN assessed the resident and called EMS for what they thought was a specific type of medical emergency. While waiting on EMS, the A-RPN did not perform a procedure on the resident, attempt to locate a type of machine from another RHA to perform another type of procedure or call for assistance from more senior medical staff.

DPP/IPAC lead acknowledged that the home did not have a written medical emergency plan/protocol for this type of medical emergency with defined staff roles and responsibilities for responding to a medical emergency.

Sources: Resident's clinical records, home's investigation notes, interviews with a PCA, A-RPN, former ADOC and DPP/IPAC lead.

This order must be complied with by November 10, 2025

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.