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: November 4, 2025

Inspection Number: 2025-1337-0006

Inspection Type:
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): October 14-17, 20-24, 27, 28, and November 4, 2025.

The inspection occurred offsite on the following date(s): October 24, 30, 31, 2025 and November 3-4, 2025.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
-A Follow-up related to Infection prevention and control;
-Two Follow ups related to plan of care;
- CI: 2852-000122-25 - Related to injury of unknown cause;
-CI: 2852-000123-25 - Related to neglect of a resident;
-CI: 2852-000152-25 - Related to improper care of a resident;
- CI: 2852-000162-25; CI: 2852-000158-25; CI: 2852-000173-25; and CI: 2852-000166-25; - Related to falls;
- CI: 2852-000169-25 - Related to staff to resident abuse;
- CI: 2852-000176-25 - Related to a communicable disease outbreak.

The following intakes were completed during this inspection:
- CI: 2852-000126-25; CI: 2852-000133-25; and Intake: #00151852/ CI: 2852-000139-25 - Related to falls;
- CI: 2852-000143-25; CI: 2852-000151-25 - Related to communicable disease outbreaks.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1337-0002 related to O. Reg. 246/22, s. 102 (8)
Order #001 from Inspection #2025-1337-0003 related to FLTCA, 2021, s. 6 (4) (a)
Order #002 from Inspection #2025-1337-0003 related to FLTCA, 2021, s. 6 (7)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (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 a resident's plan of care, related to an intervention, was provided as specified in their plan. On a specified date, a resident fell and sustained an injury. Two Personal Care Assistants (PCAs) and a Registered Nurse (RN) all confirmed that a specified intervention was not in place at the time of the resident's fall.

Sources: A resident's plan of care, interviews with to PCA's and an RN.

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 a resident's plan of care was revised when their care needs changed. Specifically, A PCA and the Assistant Director of Care (ADOC) both confirmed that the resident's care plan was no longer accurate, related to a care need.

Sources: A resident's care records; Interviews with a PCA and ADOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond, and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to ensure the investigation results were reported to the Director related to an incident of suspected neglect of a resident. The home indicated that after education was provided to the staff the investigation ceased. The Resident Assessment Instrument (RAI) Coordinator acknowledged that the home did not complete the investigation and did not report the results to the Director.

Sources: CIS Report #2852-000123-25, Interview with the RAI Coordinator.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with in relation to Hand Hygiene. In accordance with Additional Requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022) revised September 2023, the licensee has failed to ensure that hand hygiene was completed before and after contact with the resident's environment.

Sources: Inspector observations; Interviews with staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident’s substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident’s health or well-being; and

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified immediately upon the licensee becoming aware of a suspected incident of a resident neglect that resulted in an injury. After submitting a CI to the Director, the home failed to inform the resident's SDM of the incident.

Sources: A CI Report, a resident's clinical records, and Interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 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 when a resident was transferred to hospital and sustained injury. The Director was informed of the significant change in resident status six business days later.

Sources: A CI report; A resident's clinical records.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 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)]:
1) Retrain all PCAs and registered staff on a specific home area (all shifts) on the home's Skin & Wound Prevention and Management Program, and Pain Management Program, related to a new area of altered skin integrity. Topics should include, at minimum, early recognition, roles and responsibilities, timely assessments, appropriate assessment tools, interventions, care planning, documentation requirements, referral process and process for communication between staff on the same shift and endorsements between shifts.
2) Retrain all PCAs and registered staff (all shifts) related to the home's policy on the prevention of neglect.
3) Review a case study of the management of a resident's altered skin integrity with all staff, identify missed opportunities, learnings, and corrective actions (if any).

4) Develop and implement a plan to audit compliance with the home's Skin and Wound Prevention and Management Program on an identified home area, including an audit to assess a staff's compliance with the program.
5) Maintain a written record of all retraining and education in steps 1-3, including the dates and times, signed attendance, staff names and designations, and the name and title of the person(s) who provided the training.
6) Maintain a written record of the audit plan and audits conducted in step 4, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits, and actions taken in response.

Grounds

A. The licensee has failed to ensure that a resident was protected from abuse by a staff, related to care provided by a staff member.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain." and defines sexual abuse as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member."

A review of records, and interviews, confirmed that the care provided to a resident was consistent with physical and sexual abuse.

Sources: Home's Investigation File; Interviews with staff.

B. The licensee has failed to ensure a resident was not neglected by staff related to the management of an area of altered skin integrity.

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.

i) Assessments and interventions were not implemented on a resident with an area of altered skin integrity, when the concern was first identified. A Registered Practical Nurse (RPN) indicated they saw an area of altered skin integrity in the same area but did not

conduct any assessment or initiate any interventions. Multiple PCAs across all three shifts continued to document the presence of the altered skin integrity for approximately five weeks without any assessments or interventions initiated. The first assessment of the site indicated a significant deterioration.

ii) The resident experienced pain during the period when the area of altered skin integrity went unassessed, and continued to experience pain after the site was assessed as only one pain assessment was completed.

iii) The staff failed to collaborate in the assessment of the resident's altered skin integrity and pain for approximately five weeks.

iv) Following the first assessment of altered skin integrity, weekly skin assessments were missed on multiple occasions.

The NP and RAI Coordinator both acknowledged that the resident was neglected in the management of altered skin integrity and related pain. When the resident's altered skin integrity was left untreated, there was an increased risk of the site worsening, unmanaged pain, and other negative health outcomes. The site worsened, became painful, and infected.

Sources: A resident's clinical records, the home's policy for Prevention and Investigation of Abuse and Neglect (M1-010, Revised December 2023), Pain Management Program (M2-840, Revised June 2024), and Skin and Wound Care Program (M2-1000, Revised September 2024), interviews with multiple PCAs, registered staff, NP, and the RAI Coordinator.

This order must be complied with by December 30, 2025

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

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 #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, 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:

Compliance Order was issued in inspection #2025-1337-0005 to FLTCA s. 24 (1) Duty to Protect on September 25, 2025.

Compliance Order was issued in inspection #2024-1337-0004 to FLTCA s. 24 (1) Duty to Protect on July 19, 2024.

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.

COMPLIANCE ORDER CO #002 Transferring and positioning techniques

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee shall:
1) Re-train an RN and RPN on the home's policy titled Lifts and Transfers (M2-750).
2) Create a case study scenario of the two incidents of unsafe transferring and positioning detailed in the grounds below, and review with an RN and RPN, highlighting missed opportunities, learnings and corrective actions (if any).
3) Maintain records of the above training and review, including the content of the case study, content of the review, date of the review, names of the staff who provided the review and staff signed attendance of training.

Grounds

The licensee has failed to ensure that staff used safe transferring and positioning devices when transferring two residents.

(i) On a specific day a resident fell and was lifted manually by staff from the floor back to their wheelchair. The resident was transferred to the hospital and was subsequently diagnosed with an injury.

The home's "Zero Lift" transfer procedure was not complied with when a resident was manually lifted by staff. A PCA and RN both confirmed that the resident was lifted manually by staff post-fall. An ADOC acknowledged that it was not a safe transfer and

staff were expected to use a mechanical lift when assisting residents post-fall.

Sources: A resident's clinical records, Lifts and Transfer M2-750 (December 7, 2024) and interviews with two PCAs, RN, and ADOC.

ii) On a specified date a resident fell and was lifted manually by staff from the floor back to their bed. The resident was admitted to the hospital and subsequently diagnosed with an injury.

The home's Zero Lift procedure was not complied for the resident when they were manually lifted by staff. A RPN acknowledged that it was not a safe transfer and they should have used the mechanical lift when assisting the resident post-fall.

There was increased risk of injury to the two residents and staff as a result of these improper transfers.

Sources: A Resident's clinical records; Home's Lifts and Transfer M2-750 (December 7, 2024) and interview with staff.

This order must be complied with by December 30, 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.