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

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Public Report

Report Issue Date: November 17, 2025
Inspection Number: 2025-1337-0007
Inspection Type: Complaint
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 20-24, 27-31, and November 3-7, 10, 12-13, 2025
The inspection occurred offsite on the following date(s): November 14, 2025

The following Complaint intake(s) was inspected:
- Intake: #00156943 - related to multiple care concerns of a resident

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

Resident Care and Support Services
Continence Care
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 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.

A resident was not treated with courtesy, dignity, or respect during several care incidents.
i. On a specific date, a Personal Care Attendant (PCA) ignored the resident's questions during personal care provision.
ii. On a specific date, two staff administered a medication without the resident's consent. The home's investigation found the resident "was treated roughly, without regard for their dignity".
iii. On a specific date, a PCA entered the resident's room with their head covered and a mask covering their mouth and nose, and the resident repeatedly verbalized they did not know what was happening.
The Director of Professional Practice and Infection Prevention and Control Lead (DPP–IPAC Lead) acknowledged that in all of these scenarios, staff failed to provide care with courtesy, dignity, and respect.

Sources: Video footage records; resident care plan; home's investigation notes; and interview with DPP-IPAC Lead.

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) 19. ii.
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:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

A medication was administered to a resident without their consent on a specific date. The home's investigation notes indicated the resident was, "surprised, hurt, and upset" by the administration. DPP-IPAC Lead acknowledged that staff should not have

administered the medication as the resident did not provide consent.

Sources: Video footage records; Record of Consent to Treatment Discussion form; resident care plan; home's investigation notes; interview with DPP-IPAC Lead.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 plan of care for a resident did not provide clear directions to staff regarding consent and treatment. A Record of Consent to Treatment form contained conflicting information related to treatment and medication administration, and the resident's capacity to consent to treatment. Staff interviews showed inconsistent understanding of the resident’s capacity.

Sources: Record of Consent to Treatment Discussion form; resident care plan; interviews with an Associate Director of Care (ADOC), a Registered Practical Nurse (RPN), and DPP-IPAC Lead.

WRITTEN NOTIFICATION: Plan of Care

NC #004 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.

A resident was assessed at risk for falls. Fall interventions to minimize the resident's risk of falls were outlined in the plan of care. However, on a specific date, the resident was transferred without the implementation of several fall interventions.

Sources: Video footage records, resident care plan, interviews with the Physiotherapist

(PT) and DPP-IPAC Lead.

WRITTEN NOTIFICATION: Duty to Protect

NC #005 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.

A resident required toileting assistance and had a fall intervention strategy.

On two specific dates, the resident self-toileted four times. Three out of the four times the fall intervention strategy was initiated with no staff attending to the resident. A staff attended to the resident once, but did not provide any assistance. The DPP-IPAC Lead acknowledged that the resident was not consistently attended to when the fall intervention was initiated, and toileting assistance was not provided.

Sources: Video footage records, resident care plan, interview with the DPP-IPAC Lead.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

i) On a specific date, a PCA transferred a resident from sitting to standing by manually pulling their arms. A PT and the DPP-IPAC Lead acknowledged that a safe transferring technique was not utilized during the transfer.

Sources: Video footage records, resident care plan, interviews with the PT and DPP-IPAC Lead.

ii) A resident had an unwitnessed fall on a specific date.

Three staff manually transferred a resident from the floor. A PT and the DPP-IPAC Lead acknowledged that the resident should have been transferred using a mechanical lift according to the home's policy.

Sources: Video footage records, resident care plan, the home's policy, interviews with two PCAs, the PT, and the DPP-IPAC Lead.

WRITTEN NOTIFICATION: Bedtime and Rest Routines

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

A resident's television (TV) was left on during the night at varying volumes on two specific dates. A PCA stated that the general practice at night was to have the TV turned off in residents' rooms. The DPP-IPAC Lead acknowledged that having the TV turned off would promote restful sleep.

Sources: Video footage records, resident care plan, and interviews with the PCA and the DPP-IPAC Lead.

WRITTEN NOTIFICATION: Communication Methods

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 47
Communication methods
s. 47. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

Strategies were not developed and implemented to meet the needs of a resident's

compromised communication skills. The resident's plan of care did not outline strategies related to communication. DPP-IPAC Lead acknowledged that the resident was unable to participate in care provision and/or consent to treatment due to their compromised communication skills.

Sources: Video footage records; resident care plan; interviews with the RPN and DPP-IPAC Lead.

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

i) A resident had an unwitnessed fall on a specific date. A PCA moved the resident before the nurse completed their assessment.

The home’s policy titled, "Falls Prevention and Management Policy" indicated residents are not to be moved after a fall if there was suspicion of injury until a fall assessment has been conducted and appropriate action determined.

Sources: Video footage records, the home’s policy, interview with the DPP-IPAC Lead.

ii) A resident had an unwitnessed fall on a specific date and was transferred prior to a post-fall assessment.

The home’s policy titled, "Falls Prevention and Management Policy" directed staff to assess resident for any injury post fall before moving the resident. The DPP-IPAC Lead acknowledged that the RPN did not assess the resident before transferring the resident after the fall.

Sources: Video footage records, the home’s policy, interviews with the RPN, an RN,

and the DPP-IPAC Lead.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (e)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

On a specific date, a PCA instructed a resident to use their continence care product rather than offering them toileting assistance. The DPP-IPAC Lead acknowledged that it was not appropriate for staff to use continence care products as an alternative to providing toileting assistance.

Sources: Video footage records; resident care plan; interview with the DPP-IPAC Lead.