Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 16, 2013	2013_157210_0004	T-141-13; T-144-13	Critical Incident System

Licensee/Titulaire de permis

THE KENSINGTON HEALTH CENTRE
25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9

Long-Term Care Home/Foyer de soins de longue durée

THE KENSINGTON GARDENS
25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 11, 12 and 15, 2013

This inspection includes complaint T-144-13 regarding financial abuse

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Staff, General Manager Support Services,Director of Care, Administrator

During the course of the inspection, the inspector(s) reviewed the health records, hot water temperature logs, policies; observed the provision of care to residents, walked through all resident units

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Dignity, Choice and Privacy

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature of the water serving all bathtubs, used by residents is:
* 49 degrees Celsius or less, and
* controlled by a device, inaccessible to residents, that regulates the temperature.
On March 29, 2013 resident #1 was given bath by Staff #1 and sustained a burn on the right heel from the bathtub hot water. The following day the affected skin presented as 2nd degree burn. The affected area was appropriately treated. On April 12, 2013 the inspector took the water temperature of the bathtub at the unit 2East and it was 60.3 degrees Celsius. The digital temperature display on the bathtub did not work. On April 15, 2013 the inspector took the hot water temperature in the same bathtub and it was 55.5 degrees Celsius. There is no system for the staff to determine whether or not the water temperature is at a safe range of 40 to 49 degrees Celsius. [s. 90. (2) (g)]

2. The licensee failed to ensure that immediate action was taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.
On April 12, 2013 licensee was informed that the bath tub water temperature on unit 2East was 60.3 degrees Celsius. The licensee did not ensure that immediate action was taken to reduce the water temperature. [s. 90. (2) (h)]

3. The licensee failed to ensure that the hot water temperature serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.
On April 12, 2013 the water temperature of the bathtub at the unit 2West (south building) was 33.1 degrees Celsius. The digital temperature display on the bath tub was not working. [s. 90. (2) (i)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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Issued on this 17th day of April, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs