

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 torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 31, 2023

Inspection Number: 2023-1337-0003

Inspection Type:

Complaint

Critical Incident System

Licensee: The Kensington Health Centre

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

Lead Inspector Nital Sheth (500) **Inspector Digital Signature**

Additional Inspector(s)

Ann Mc Gregor (000704) was also present during this inspection.

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 12-13, 16-20, 2023.

The following intake(s) were inspected:

- Intake log #00012261-22 related to multiple care concerns
- Intake log #00013035-22 related to fall incident resulted in injury

The following intakes were completed in this inspection:

#00016546-22, 00001265-22, #00003130-22, #00002507-22, #00004583-22,
#00003914-22, #00009103-22 related to falls incidents resulted in injury

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services Infection Prevention and Control



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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: LTCHA, 2007, s. 6 (7)

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

Rational and Summary

The resident's written care plan indicated specified instructions for staff to provide personal care. The resident refused personal care on an identified day because of the specified instructions related to staff were not followed.

Assistant Director of Care (ADOC) confirmed that staff are expected to follow the plan of care and specified instructions related to the staff member should not have been followed.

Sources: Care plan, progress notes, interview with the ADOC.[500]