

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

Original Public Report

Report Issue Date: September 19, 2023	
Inspection Number: 2023-1337-0005	
Inspection Type: Critical Incident	
Licensee: The Kensington Health Centre	
Long Term Care Home and City: The Kensington Gardens, Toronto	
Lead Inspector Noreen Frederick (704758)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 8, 11, 12, 13, 2023

The following intake(s) were inspected:

- Intake: #00095477-[Critical Incident (CI): 2852-000028-23] related to Medication Administration

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Administration of drugs

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

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

The licensee shall:

1. Re-educate any agency registered nursing staff working at the home related to the current College of Nurses of Ontario (CNO) Practice Standard for Medication, with a focus on the Decision tree "Deciding About Medication Administration" to reduce the harm caused by medication errors as well as the home's Medication Administration policy.
2. The home must maintain a record of the above education, including the date, content, who facilitated the education, and signed staff attendance.

Grounds

The Licensee has failed to that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary

A resident was administered multiple high-risk medications in error by an Agency Registered Practical Nurse (RPN). These medications were not prescribed for the resident. As a result, the resident experienced several severe symptoms which led them to be transferred to the hospital for further assessment and treatment.

Agency RPN stated that they did not verify the resident's identity to ensure that the medications were being administered to the correct resident. Assistant Director of Care (ADOC) acknowledged that the RPN did not verify that the right resident was receiving the medication.

There was actual harm to the resident when they received medication which was not prescribed for them.

Sources: resident's clinical records, home's investigation notes, and interview with RPN and other staff.

[704758]

This order must be complied with by September 29, 2023

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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

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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
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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.