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
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: February 2, 2024

Inspection Number: 2024-1337-0001

Inspection Type:
Critical Incident
Follow up

Licensee: The Kensington Health Centre

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

Lead Inspector	**Inspector Digital Signature**
Ryan Randhawa (741073)	Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2024.02.12 16:34:38 -05'00'

Additional Inspector(s)
Lisa Salonen Mackay (000761)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15, 16, 18, 22-24, 2024.

The following intake(s) were inspected:

•Intake: #00102062 - Follow-up Inspection to Compliance order (CO) #001: related to dining and snack service.
•Intake: #00103088 - [Critical incident (CI): 2852-000042-23] was related to self-harm resulting in injury
•Intake: #00104167 - [CI: 2852-000050-23] was related to disease outbreak.
•Intake: #00105888 - [CI: 2852-000001-24] was related to fall with injury.

The following intake(s) were completed in this inspection:
•Intake: #00102337 - [CI: 2852-000039-23] and Intake: #00104036 - [CI: 2852-000046-23] were related to fall with injury; and
•Intake: #00101511 - [CI: 2852-000037-23], Intake: #00101765 - [CI: 2852-000038-23], and Intake: #00105170 - [CI: 2852-000053-23] were related to disease outbreaks.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1337-0006 related to O. Reg. 246/22, s. 79 (1) 8. inspected by Lisa Salonen Mackay (000761)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

Rationale and Summary

A resident had a history of symptoms of an illness. On a day in November 2023, the resident carried out an action related to their illness which injured the resident. Staff intervened, informed the physician, and the resident was transferred to the hospital for further assessment.

The home's policy stated that the Team Leader will assess the resident and notify the physician for indications of this illness. The policy indicated that based on the assessment and severity of symptoms, the physician may order a transfer to hospital for an assessment and other interventions.

On an earlier date in November 2023, the resident expressed to a Registered Practical Nurse (RPN) that they were experiencing symptoms of the illness. The RPN

and Associate Director of Care (ADOC) indicated that the physician was not informed, and that the staff should have collaborated with the physician for their assessment of the resident's symptoms. The ADOC and the Director of Care (DOC) both acknowledged that had the staff collaborated with the physician, the appropriate assessments and interventions could have been provided to prevent the actions of the resident.

There was a risk that the resident would not receive appropriate interventions to prevent the actions related to the resident's symptoms when the interdisciplinary team did not collaborate in their assessment of their symptoms.

Sources: Resident's clinical records; the home's policy; interviews with RPN, ADOC, the DOC, and other staff.

[741073]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(f) clearly indicates when activated where the signal is coming from; and

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal was coming from.

Rationale and Summary

The inspector observed a resident's call bell was not functional when the resident and inspector pressed the call bell button. There was no audible sound or visual indicator in the hallway to alert staff that the call bell was activated when pressed. A Personal Support Worker (PSW) was present in the room and verified that the call bell was not functional and informed the inspector that they would inform staff to repair it.

The home's policy titled "Call Bells" directed staff to report immediately to maintenance if a call bell was defective and to document in Maintenance Care online as well as placing a phone call to the maintenance worker for assistance. The inspector and Director of Support Services reviewed the maintenance log and found no reports that the call bell was not functioning and required repair.

A PSW, RPN, ADOC, and the DOC indicated that there was risk if the resident's needs were not being addressed when their call bell was not functional and failed to indicate when activated where the signal was coming from.

Sources: Observations; policy titled "Call Bells" M2-140 revised February 2018; review of maintenance logs; interviews with PSW, RPN, Director of Support Services, ADOC, and the DOC.

[741073]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to comply with their pain management program when new pain was identified for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the pain management program included implementation of policies and procedures relating to communication and assessment methods for residents who were cognitively impaired.

Specifically, staff did not comply with the home's pain management policy when the resident's pain was not assessed using the Pain Assessment Tool (PAT).

Rationale and Summary

The home's policy titled "Pain Management Program" directed nurses to conduct a pain assessment using the Pain Assessment Tool (PAT) when there was a change in resident health status and when a resident reported or exhibited pain. Specifically for cognitively impaired residents, the Pain Assessment in Advanced Dementia (PAINAD) Scale was to be completed.

A resident fell and denied any pain when asked by the RPN. It was noted by the Nurse Manager (NM) that the resident moaned when repositioned, however a pain assessment was not completed. The resident continued to demonstrate signs of pain but would deny pain when asked by registered staff, refused analgesics when

offered, and refused to be transferred to hospital. The resident's substitute decision-maker (SDM) agreed with the resident's wishes not to be transferred to hospital despite staff's recommendation. The resident's health continued to decline until the resident and SDM agreed to transfer the resident to the hospital four days later where they were diagnosed with injuries.

The resident continued to demonstrate signs of pain on multiple days after the fall, however pain assessments using the PAT were not completed by registered staff.

A RPN, NM, ADOC, and the DOC acknowledged that registered staff failed to complete pain assessments when the resident was exhibiting signs of pain.

Failure to complete pain assessments for the resident increased the risk of not identifying the resident's level of the pain and risk that the resident would not receive appropriate pain management interventions.

Sources: policy titled "Pain Management Program", M2-840, revised July 2018; resident clinical records; interviews with RPN, NM, ADOC, DOC, and others.

[741073]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 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 implement a protocol issued by the Director with respect to infection prevention and control.
The license has failed to ensure personal protective equipment (PPE) was used in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) as required by Additional Precaution 9.1(f) under the IPAC Standard.

Rationale and Summary

During a COVID-19 outbreak, a PSW was observed delivering a meal tray to a resident and a Laundry Aide (LA) was observed delivering laundry to another resident with no gown or gloves. Signage on both residents' room entrances indicated they were on droplet/contact precautions. The PSW acknowledged that the room they were entering required additional precautions to be taken and confirmed that they entered the room without donning required PPE.

The DOC and Director of Support Services (DSS) acknowledged that when in a resident's room who was on droplet/contact precautions all staff were expected to wear N95 mask, face shield, gloves and gown . Failure to follow additional precautions increased the risk of infection transmission.

Source: Observations; review of IPAC Standards; and interview with PSW, DOC and DSS.

[000761]

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 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee has failed to timely notify Public Health for managing and controlling the spread of COVID-19.

Rationale and Summary

On November 10th, 2023, two residents presented with respiratory symptoms. On November 11th, 2023, two more residents were added to the respiratory line list on the same unit. Toronto Public Health was notified on November 12th, 2023, and a COVID-19 outbreak was declared.

The DOC stated Toronto Public Health should be notified if two or more residents have symptoms and confirmed that the four residents identified on the respiratory line list were COVID positive. The DOC acknowledged the outbreak management reporting protocols were not followed. Failure to contact Toronto Public Health increased the risk of an uncontrolled, prolonged outbreak.

Source: Review of Respiratory Outbreak Line List (Toronto Public Health); Critical

Incident Report 2852-000038-23; and interview with DOC.

[000761]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary

Two days in November 2023, two critical incident reports were submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet dated August 18, 2023, indicated that for critical incidents occurring outside of business hours, to immediately call the Service Ontario After-Hours Line.

The DOC confirmed that the home submitted both critical incident reports outside of

normal business hours but did not call the Service Ontario After-Hours Line.

Sources: Critical Incident Reports 2852-000037-23 and 2852-000038-23; MLTC Reporting Requirements - reference sheet; and interview with DOC.

[000761]