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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Original Public Report

Report Issue Date: September 27, 2024
Inspection Number: 2024-1337-0006
Inspection Type: Complaint Critical Incident
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): September 4, 5, 6, 10, 11, 12, 13, 16, 17, 18, 2024
The inspection occurred offsite on the following date(s): September 23, 2024

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00118213, related to allegation of neglect and infection prevention and control;
- Intake: #0011930, related to improper/incompetent treatment/care, change in health status, nutrition and hydration and plan of care;
- Intake: #00120099, related to a change in health status of a resident and;
- Intake: #00119894, related to a fall with injury.

The following Complaint intake was inspected:

- Intake: #00118400, related to allegation of abuse.

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

Resident Care and Support Services
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to a resident shall immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint regarding an allegation of abuse towards a resident by a Personal Care Attendant (PCA). The complainant indicated they made the allegation in 2023, to the Director of Care (DOC).

The allegation of abuse was documented by the home in 2023, and the DOC acknowledged that the allegation was not reported to the Director.

Failure to report the abuse allegation prevented the MLTC to take any action to respond to the allegation.

Sources: Review of Complaint Form; and interviews with the complainant and DOC.

WRITTEN NOTIFICATION: MENU PLANNING

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The licensee has failed to ensure that a resident was offered a between-meal beverage in the morning.

Rationale and Summary

The home submitted a critical incident (CI) regarding a resident's concerns of their meals and snacks. The resident was concerned they did not receive their between-meal beverage in the morning on one occasion.

The complaint investigation documented that the resident was not satisfied with their meals and choices which negatively impacted the resident.

A PCA acknowledged they missed offering the resident their morning beverage.

Failure to offer the resident with their between-meal beverage in the morning may have affected the resident's emotional well-being.

Sources: Review of CI report and home's investigation notes and complaint; and interviews with a PCA and other staff.

WRITTEN NOTIFICATION: FOOD PRODUCTION

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions.

The licensee has failed to ensure that menu substitutions were communicated to a resident and staff.

Rationale and Summary

The home submitted a CI related to a resident's concerns regarding their meals not matching the daily menu.

On one occasion, an entree was substituted and was not communicated to a resident. A Registered Practical Nurse (RPN) stated the dietary staff did not inform the unit staff of the substitution, until the resident complained. The resident was upset and did eat their meal.

The resident indicated they get upset when staff do not communicate menu substitutions.

Failure to notify the resident and staff of menu substitutions affected the resident's emotional well-being.

Sources: Review of CI report, a resident's Three Week Menu and progress notes; and interviews with a resident, RPN and other staff.

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the seven-day and daily menus were communicated to residents.

Rationale and Summary

The seven day and daily menus were observed not posted in one resident home area (RHA) on September 17 and 18, 2024. The PCA staff indicated that the electronic monitor that communicated the seven day and daily menus was not working for a few days.

A RPN acknowledged that the menus were not communicated to residents, until the time of meal service. The Director of Nutrition Services indicated that communication of the seven day and daily menus to residents were posted through the electronic monitor outside the RHA dining room. They acknowledged that the monitor was not working and the menus were not communicated to residents until meal service.
Failure to communicate the seven day and daily menus to residents in the RHA may have affected the residents' dining experience.

Sources: Observations on September 17 and 18, 2024 in one RHA; and interviews with RPN, Director of Nutrition Services and oher staff.

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 (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 ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

A) The home has failed to ensure that following the resolution of an outbreak, the outbreak management team (OMT) and the interdisciplinary IPAC team conducted a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak and a summary of findings created that made recommendations to the licensee for improvements to outbreak management practices, as required by Additional Requirement 4.3 under the IPAC Standard.

Rationale and Summary

The home was in a confirmed COVID-19 outbreak in one RHA. The IPAC Practitioner acknowledged that a debrief session with the home's OMT was not conducted and a summary of findings was not created following the resolution of the outbreak.

Failure to conduct a debrief session and summary of findings following the resolution of their COVID-19 outbreak may have affected the effectiveness of the

home's outbreak management practices.

Sources: Review of CI report and IPAC Standard for Long-Term Care Homes, Revised September 2023; and interview with the IPAC Practitioner.

B) The home has failed to ensure that there were policies in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, as required by Additional Requirement 5.6 under the IPAC Standard.

Rationale and Summary

The home's policies on environmental cleaning and disinfection and outbreak management did not include the determination of the frequency of surface cleaning and disinfection using a risk stratification approach.

The Senior Director, Facilities Management and the IPAC Practictioner both acknowledged that the home did not have a policy.

Failure to have a policy that determined the frequency of surface cleaning and disinfection using a risk stratification approach may affect the home's IPAC practices in the prevention and control of infections in the home.

Sources: Review of policies: Cleaning Procedures, RES-ENV-03.001, Revised March 2017, Discharge Cleaning, RES-ENV-04.001, October 2015, Disinfection of Shared Equipment, M6-085, Revised January 2014, Infection Control - Environmental Services, CORP-ENV-09.001, Revised October 2015, Outbreak Management, #M6-309, Revised December 2022, Outbreak Contingency Plan, M6-300, Revised June 2018, and Email from Senior Director, Facilities Management, dated September 17, 2024 and IPAC Standard for Long-Term Care Homes, Revised September 2023 ; and interviews with IPAC Practitioner and other staff.

C) The home has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program. Specifically, hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact), as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary

The home received a written complaint that indicated a PCA performed an aseptic procedure to a resident without performing hand hygiene.

The home's investigation documented that the PCA was in contact with the resident's environment looking for clothing with gloved hands and then proceeded to perform the procedure to the resident without changing their gloves and performing hand hygiene

The PCA acknowledged they did not conduct hand hygiene before they performed the procedure to the the resident.

There was a risk of infection transmission to the resident when the PCA did not perform hand hygiene prior to the aseptic procedure.

Sources: Review of CI report, home's investigation notes and IPAC Standard for Long-Term Care Homes, Revised September 2023; and interviews with a PCA and other staff.

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. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift, (a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that on every shift, a resident's symptoms indicating the presence of infection were monitored.

Rationale and Summary

A resident displayed symptoms indicating the presence of an infection and was on additional precautions. Their symptoms of infection were not monitored for six shifts.

The IPAC Practitioner acknowledged that the resident's symptoms of infection were not monitored every shift as required.

Failure of staff to monitor the resident's symptoms of infection every shift placed the resident at risk of delayed treatment of their infection.

Sources: Review of a resident's clinical records and Outbreak Line List; and interview with the IPAC Practitioner.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes, (e) every date on which any response was provided to the

complainant and a description of the response.

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response regarding a written complaint of the care of a resident.

Rationale and Summary

The home received a written complaint regarding the care of a resident. The home was unable to provide documentation on the response provided to the complainant of the outcome of their investigation.

The DOC acknowledged that the home verbally provided the outcome of the investigation, and the response was not documented.

Failure to ensure there was a documented record of their response to the complainant may affect the home's review and analysis of their complaints when determining improvements that may be required.

Sources: Review CI report, home's investigation notes and a resident's progress notes; and interview with the DOC.

WRITTEN NOTIFICATION: CMOH and MOH

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health

Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed in the home.

Specifically, results of their weekly infection prevention and control (IPAC) audits during their confirmed COVID-19 outbreak were not reviewed by the OMT, as part of the recommendations of the CMOH.

Rationale and Summary

The home was in a confirmed COVID-19 Outbreak on one RHA. Weekly IPAC audits were completed, but the results of the audits were not reviewed by the home's OMT, which was acknowledged by the IPAC Practitioner.

Failure to review the results of the weekly audits may have affected the home's assessment of their IPAC practices in the management of COVID-19 outbreaks.

Sources: Two IPAC Self-Assessment Audits for Long-Term Care and Retirement Homes and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings Ministry of Health, April 2024; and interview with the IPAC Practitioner.