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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: January 10, 2025

Inspection Number: 2024-1337-0007

Inspection Type:
Critical Incident
Follow up

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): November 4, 5, 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, and December 2, 2024.

The following intake(s) were inspected:

- Intake: #00120424 / Critical Incident Systems (CIS) #2852-000089-24 and intake #00121871 / CIS #2852-000113-24 were related to alleged improper care with dietary requirements and late reporting.
- Intake: #00120720 / CIS #2852-000099-24 and #2852-000109-24 were related to alleged improper care and neglect with wound care and pain management.
- Intake: #00121736 / CIS #2852-000111-24; intake #00127418 / CIS #2852-000151-24 and intake: #00128076 / CIS #2852-000155-24 were related to alleged improper care and neglect.
- Intake: #00125494 / CIS #2852-000136-24 - was related to alleged improper pain management.
- Intake: #00127516 / CIS #2852-000153-24 and intake #00129015 / CIS #2852-000169-24 were related to an outbreak.
- Intake: #00122054 2024 was related to duty to protect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1337-0004 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Pain 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) (b)
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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.
The licensee failed to ensure that the staff involved in the different aspects of

resident #005's care collaborated with each other, in the development and implementation of the plan of care so that different aspects of care were integrated and consistent with and complemented each other. Specifically, the staff failed to collaborate with respect to a medication discrepancy, pain and vital signs.

Rationale and Summary

(i) A resident was admitted to the home and received a discharge summary from a previous facility prior to admission indicating that the resident's discharge medications included a pain management regime for pain which was documented by a Registered Practical Nurse (RPN). The RPN did not inform the Nurse Practitioner (NP) or the physician of the medication discrepancy and failed to share this with the incoming nurse. The incoming nurse was unaware of the medication discrepancy until the resident requested pain medication. The incoming nurse did not notify the physician of the resident's request for pain medication and failed to communicate this to the next shift.

On the next shift staff became aware of the discrepancy when the resident again requested pain medication and notified staff that they were receiving pain medication at the previous facility. No communication was sent to the physician until the end of that shift, resulting in the resident receiving pain medication until approximately six hours later.

The resident was transferred to hospital the next day with uncontrolled pain.

Assistant Director of Care (ADOC), NM and the Director of Care (DOC) acknowledged that staff did not collaborate effectively to develop and implement the plan of care when the medical team, nursing management, and incoming shifts were not informed of the medication discrepancy.

Failure of staff to collaborate with the medical team, nursing management, and incoming shifts to reconcile the medication led to ineffective pain management and

worsening pain requiring hospitalization.

(ii) A resident was admitted to the home and was assessed by an RPN to have pain. There was no collaboration among staff in managing the resident's pain. The ADOC and NP both indicated that they were not informed of the resident's pain. An RPN assessed the resident's pain on four occasions, pain was rated between five and 10, however the RPN documented that the resident's vital signs were stable. The shift exchange report indicated that the resident was stable with no mention of pain. The NM indicated they were not informed of resident's pain.

The resident's clinical records indicated that the physician was not informed of the resident's pain on this shift. The resident was transferred to hospital with uncontrolled pain.

ADOC, NM, NP and the DOC all acknowledged that staff did not collaborate effectively to develop and implement the plan of care when the medical team, nursing management, and incoming shifts were not informed of the resident's pain in a timely manner.

Failure of staff to collaborate with the medical team, nursing management, and incoming shifts related to the resident's pain symptoms led to ineffective pain management and worsening pain requiring hospitalization.

(iii) Upon admission to the home, an RPN recorded a resident's Blood Pressure (BP) at a low level. On the same day, a second RPN recorded the resident's BP at a significantly lower level. The ADOC and NP indicated that both readings were considered low given the resident's medical history. The ADOC and NM both indicated they were not informed of the resident's low BP.

The DOC acknowledged that both RPNs did not collaborate effectively to develop and implement the plan of care when the medical team, nursing management, and

incoming shifts were not informed of the resident's low BP and elevated pulse.

Failure of staff to collaborate with the medical team, nursing management, and incoming shifts related the resident's low BP and elevated pulse, may have contributed to their worsening condition requiring hospitalization.

Sources: Review of the resident's clinical records, the home's case review notes, Interviews with the RN, NP, ADOC, DOC and other relevant staff.
[000857]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of a resident's plan of care.

Rationale and Summary
A Critical Incident Systems (CIS) report was submitted to the Director for a resident improper care related to dietary requirements resulting in two choking incidents.

A resident experienced choking during a meal on a certain food type while being assisted/supervised by an RPN. They were referred to the Registered Dietician (RD) for assessment and diet order change. The new diet order did not specifically indicate not to serve the resident that food type that caused the initial choking.

The resident experienced a second choking incident during a meal while eating the same food type that had caused the previous choking two days later. The resident's Care Plan was not updated to reflect the change until after the second choking incident had occurred.

The RD acknowledged that staff who provided direct care to the resident should have been made aware of their dietary changes.

There was moderate risk to the resident when staff who provided direct care to the resident, were not made aware of the contents of the resident's plan of care.

Sources: CIS #2852-000089-24/2852-0000113-24, the resident's electronic health records and paper chart, interview with the PSW, RPNs, RD and others.
[698]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately report the written complaint related to a resident's choking incidents to the Director.

Rationale and Summary

The home received a written complaint related to a resident's two choking incidents. The written complaint was not reported to the Director until three weeks later.

The Director of Care (DOC) indicated that they should have called the Service Ontario After-Hours, the same day they received the written complaint followed by a CIS report.

By failing to immediately forward the written complaint regarding the care of a resident, the Director was unable to respond to the incident in a timely manner.

Sources: CIS report #2852-000113-24, E-mail Correspondence between Complainant and Licensee, and interview with the DOC.
[698]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A pain medication was administered to a resident on four occasions and follow-up pain ratings on the effectiveness of the medication were between five and 12. The resident's clinical records indicated that no pain assessments were completed using

a clinically appropriate assessment instrument when pain was not relieved at these times. The resident was transferred to hospital with uncontrolled pain.

The Nurse Manager (NM) and the Director of Care (DOC) both acknowledged that assessments for pain using a clinically appropriate assessment instrument should have been completed at each of the times when the resident's pain was not relieved after pain medications were administered.

Failure to complete pain assessments using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial interventions may have contributed to delays and inadequate interventions to manage the resident's pain.

Sources: The resident's clinical records, the home's case review notes and root cause analysis, the home's pain management policy (Pain Management Program, M2-840, Revised Jul 2018), Interviews with the NM and DOC.
[000857]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Provide training to all Personal Care Assistants (PCAs) on two Resident Home Areas, on the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (rev. Sept. 2023) routine practices, specifically:

- Section 9.1 (b) related to 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 bodily fluid exposure risk, and after resident/resident environment contact); and
- section 9.1 (d) related to proper use of personal protective equipment (PPE) including appropriate selection, application, removal, and disposal.

2) Document and maintain a written record of the training provided, including the date(s) training was held, an overview of the topics covered, method of delivery, the name and credentials of the staff member who provided the training, the name and credentials of the staff member receiving the training, and the recipient staff's signature that they understood the training provided.

3) Conduct weekly audits to observe PCAs donning and doffing PPE and performing hand hygiene, for four weeks.

4) Maintain a record of the audits completed, including date, shift time, person completing the audit, observations made, and content of on-the-spot education provided and/or other corrective actions taken where required.

5) These records must be readily available for inspector review.

Grounds
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 staff were performing hand hygiene at the

four moments of hand hygiene in accordance with the "IPAC Standard for Long Term Care Homes September 2023" (IPAC Standard), as required by Routine Practices and Additional Precautions requirements 9.1 (b) were implemented.

Rationale and Summary
(i) A housekeeping staff did not remove their gloves and perform hand hygiene before or after pulling up their mask to cover their mouth and nose on a resident home area (RHA).

(i) A second RHA was on a confirmed COVID-19 outbreak.

(ii) A Personal Care Assistant (PCA) did not perform hand hygiene after removing their PPE, then made contact with the lunch tray cart. The staff did not perform hand hygiene before donning new PPE and delivered lunch trays to multiple residents on droplet-contact precautions.

Grounds
(B) The home has failed to ensure staff were properly using personal protective equipment (PPE), including appropriate selection, application, removal and disposal, in accordance with the "IPAC Standard for Long Term Care Homes September 2023" (IPAC Standard), as required by Routine Practices and Additional Precautions requirements 9.1 (d).

Rationale and Summary
(i) On an identified date on a RHA, a PCA was wearing their mask hanging from their ear while assisting a resident in the hallway in their wheelchair. The staff did not perform hand hygiene before or after putting their mask and re-assisted the resident.

(ii) On the same date, another PCA was wearing their mask under their chin while assisting a resident with their walker in the hallway. The staff did not perform hand

hygiene before or after putting their mask on their face and re-assisted the resident.

(iii) On a different date, a PCA and two other staff members were wearing their masks under their chin or hanging from their ear while in the TV room with residents present.

(iv) On that same date, a housekeeping staff was wearing gloves and their mask hanging from their ear while cleaning the hallway.

On an identified date, a RHA was on a confirmed COVID-19 outbreak.

(i) A PCA wearing gown, gloves, N95 mask and face shield entered a resident's room who was on droplet-contact precautions. The staff exited the resident's room and removed their gown and face shield before removing their gloves. The staff member did not remove or change their N95 mask.

(ii) A PCA entered each isolation room with their gown untied at the back.

(iii) A contracted staff was wearing their mask hanging from their ear while in the hallway.

(iv) A visitor was wearing no PPE while visiting a resident.

The home's policy titled "Hand Hygiene" directed staff to perform hand hygiene as per the essential four moments of hand hygiene including, but not limited to: before contacting the residents, after contacting any items that was used by residents, before and after entering and leaving an isolation area, and before and after removal of PPE including gloves, masks and gowns.

Interview with the IPAC Practitioner confirmed that staff were expected to clean their hands as per the four moments of hand hygiene, including, before and after

interacting with the resident and their environment, and before and after donning/doffing PPE, including surgical masks. In addition, staff were expected to don and doff PPE in the correct sequence and wear full PPE as per the isolation signage posted on residents' doors, including their gown being tied at the back.

Failure to ensure staff performed hand hygiene before and after resident interactions, and before donning and doffing PPE increased the risk of spreading infectious agents. Failure to ensure staff and visitors properly use PPE, including appropriate selection, application, removal and disposal increased the risk of spreading infectious agents.

Sources: Observations conducted on November 7, 8 and 20, 2024, the home's Hand Hygiene Policy (Policy #CORP-INF-08.001) revised October 25, 2024, the home's Personal Protective Equipment (PPE) Policy (Policy #CORP-OHS-16.001) revised November 2021 and interview with IPAC Practitioner.
[707428]

This order must be complied with by May 5, 2025

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

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
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.