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

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Public Report

Report Issue Date: February 24, 2025

Inspection Number: 2025-1337-0001

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): January 30, 31, 2025 and February 3, 4, 6, 7, 10, 11, 12, 14, 19, 20, 2025.

The inspection occurred offsite on the following date(s): February 13, 2025

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00128204 [2852-000162-24] – related to potential neglect and improper pain management of a resident
- Intake: #00128507 [2852-000166-24]- related to potential neglect and improper care of a resident resulting in a fall with injury
- Intake: #00128589 [2852-000168-24] – related to improper care of a resident
- Intake: #00131719 [2852-000190-24] - related to a medication incident resulting in alteration of a resident's health status
- Intake: #00133068 [2852-000201-24 – related to potential abuse and improper care of a resident resulting in an injury
- Intakes: #00136554 [2852-000003-25] – related to an outbreak
- Intakes: #00127870 [2852-000154-24] and #00132110 [2852-000192-24] – related to a fall of a resident resulting in an injury

The following intakes were completed:

- Intakes: #00136557 [2852-000004-25], #00137471 [2852-00011-25], #00137733 [2852-000014-25], #00131174 [2852-000187-24] and #00134882 [2852-000219-24] were related to an outbreak
- Intakes: #00136039 [2852-000001-25] and #00128266 [2852-000161-24] were related to a fall of a resident resulting in injury

The following complaint was inspected:

- Intake: #00136970 - related to concerns regarding pest control, housekeeping and responsive behaviors

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that a resident received an assessment when the care set out in their plan of care related to transfers and toileting was revised from requiring two-person extensive assistance to one-person extensive assistance.

Sources: A resident's clinical records; Home's Lifts and Transfers Policy and interviews with a Registered Practical Nurse (RPN) and Associate Director of care.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care related to toileting was provided as specified in the plan. Specifically, a Personal Support Worker (PSW) was observed independently assisting a resident with toileting. The resident's care plan at the time of the observation indicated that they required two-person extensive assistance.

Sources: Observations; Resident's clinical records; Interviews with a PSW and Registered Nurse (RN).

WRITTEN NOTIFICATION: Complaints Procedure - Licensee

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 forward to the Director a written complaint that they received alleging improper care of a resident.

The Director of Care (DOC) received a written complaint alleging improper care of a resident. ADOC stated this concern was not forwarded to the Director immediately.

Sources: A written complaint to the home alleging improper care of a resident and an interview with the ADOC.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure a PSW used safe transferring techniques when they assisted a resident. The resident was found to be improperly transferred with no staff present in the room.

Sources: Resident's clinical records; Long Term Care Homes (LTCH) Investigation Notes; Interview with ADOC and others.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident has fallen, the resident was assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

An RPN did not complete the Post-fall assessment for a resident's fall. The ADOC acknowledged that this assessment was not completed for the resident.

Sources: Resident's clinical records; Interviews with an RPN and ADOC.

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure no drug was administered to a resident in the home unless the drug had been prescribed for the resident. An RPN erroneously administered medications intended for another resident to the resident. As a result,

the resident experienced a change in health status.

Sources: Resident's clinical records; LTCH investigation notes; Interviews with an RPN and others.