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: April 9, 2025
Inspection Number: 2025-1337-0002
Inspection Type: Proactive Compliance Inspection
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): March 26-28, 31, 2025 and April 1-4, 7-9, 2025

The following intake(s) were inspected:
- Intake: #00142865 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a planned dietary intervention was included in a resident's written plan of care.

On March 27, 2025, a resident was observed using a dietary intervention. The intervention was not included in their written plan of care.

On April 2, 2025, staff added the dietary intervention to the resident's care plan.

Sources: Observations; review of the resident's clinical records; and interviews with relevant staff.

Date Remedy Implemented: April 2, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The Licensee has failed to ensure that a door that residents should not have access to was kept closed and locked.

On March 26, 2025, during the initial tour, a clean linen door was left ajar using paper towels. It was immediately removed when brought to staff's attention.

Sources: Observation on March 26, 2025; and interview with relevant staff.

Date Remedy Implemented: March 26, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. ii.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
ii. equipped with a door access control system that is kept on at all times, and

The licensee has failed to ensure that a balcony door was equipped with a door access control system that was kept on at all times.

On March 26, 2025, during the initial tour, the door access control system for a balcony door was not activated, during sub-zero temperatures. Staff immediately locked the door.

Sources: Observations on March 26, 2025.

Date Remedy Implemented: March 26, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

On March 26, 2025, during the initial tour of the home, there was no visitor policy observed posted.

On March 27, 2025, the visitor policy was posted on the home's bulletin boards.

Sources: Observations; and interviews with relevant staff.

Date Remedy Implemented: March 27, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development of the resident's plan of care related to bathing.

The SDM was not consulted when staff changed the resident's bathing method.

Sources: Review of the resident's clinical records; and interview with the resident's SDM and relevant staff.

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee failed to ensure that the outcome of a bathing assessment affecting a resident's plan of care was documented.

Sources: Review of the resident's clinical records; and interview with relevant staff.

WRITTEN NOTIFICATION: Doors in a Home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that a door leading to a non-residential area was kept closed and locked when it was not being supervised by staff.

On March 26, 2025, a door leading into a housekeeping room, containing multiple chemicals, was left unsupervised and unlocked.

Sources: Observation on March 26, 2025.

WRITTEN NOTIFICATION: Air Temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.

The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home. Air temperature measurements were not taken of resident bedrooms

between February 26-28 and on March 26, 2025.

Sources: Review of home's air temperature records; and interview with relevant staff.

WRITTEN NOTIFICATION: Air Temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature required to be measured in resident bedrooms and common areas was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Between February and March 2025, the home was measuring resident rooms only once per day. Temperatures were inconsistently measured in the common areas with morning and evening measurements frequently missed.

Sources: Review of home's air temperature records; and interview with relevant staff.

WRITTEN NOTIFICATION: General Requirements

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements

s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to complete the annual evaluation of the Pain Management and Skin and Wound Care Programs
(1) The Pain Management Program was not evaluated in 2024
(2) The Skin and Wound Care Program was not evaluated in 2024

Sources: Interview with relevant staff.

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that there was a written record related to staffing plan evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. The home did not provide written records related to staffing plan evaluation for the 2023 and 2024 fiscal years.

Sources: Interview with relevant staff.

WRITTEN NOTIFICATION: Houskeeping

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that residents' care equipment, specifically a mechanical lift, was disinfected after use.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that procedures were developed and implemented for cleaning and disinfection of the resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

Specifically, a staff member failed to comply with the home's Cleaning and Disinfection of Medical Equipment/Devices policy, which required staff to disinfect shared equipment between uses with a low level disinfectant wipe. The staff member used the same equipment to transfer two separate residents without disinfecting the equipment.

Sources: Observations on April 3, 2025; and interview with relevant staff.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Retrain two staff on the home's hand hygiene policy including the four moments of hand hygiene;
2. Audit hand hygiene practices for the two staff at a minimum of four times a week for four weeks;
3. Maintain a record of the training, including the dates, staff names and designations, signed attendance, and name and title of the person(s) who provided the training;
4. Maintain a record of the audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

Grounds

The licensee has failed to ensure that two staff members participated in the implementation of the home's IPAC program related to hand hygiene.

1) On March 26, 2025, a staff member wore a pair of disposable gloves to transport

a laundry cart into the spa room. They wore the same pair of gloves to enter and exit the dirty linen room. They immediately went into a resident room, picked up clean linen which they took into another resident room, while wearing the same disposable gloves. The staff member did not remove the gloves and perform hand hygiene (HH) between rooms, and before and after contact with the residents and their environments.

Sources: Observations on March 26, 2025.

2) A staff member was observed on a unit that was experiencing an outbreak entering several rooms without performing HH before and after coming into contact with the residents' environments. The staff member entered multiple resident rooms, some of which were on additional precautions at the time of observation.

Sources: Observations; and interview with relevant staff.

This order must be complied with by July 7, 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.