



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
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Direction de l'amélioration de la
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 26, 2013	2013_157210_0025	T310-13, T307-13, T304-13	Complaint

Licensee/Titulaire de permis

THE KENSINGTON HEALTH CENTRE
25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9

Long-Term Care Home/Foyer de soins de longue durée

THE KENSINGTON GARDENS
25 BRUNSWICK AVENUE, TORONTO, ON, M5S-2L9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 11, 15, 16, 17, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Nurse (RN), Life Enrichment Coordinator, Director of Nursing Care, Physiotherapist (PT)

During the course of the inspection, the inspector(s) observed the provision of resident care, reviewed clinical records

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Medication

Personal Support Services

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

**WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order**

Legendé

**WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités**



Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

2. 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. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :



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1. Licensee failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

A Critical Incident report indicates that in Spring 2013 Resident #2 who uses a wheelchair for mobility went to do laundry in the laundry room that is located on a non-residential area. Resident had an unwitnessed fall in the laundry room that resulted in a hip fracture and transfer to hospital. Interview with staff indicates staff never supervised resident while doing laundry in the laundry room. Observation of the laundry room located on the main floor confirmed that it was located in a non-residential area where staff launch room, offices and a board room were located. Interview with staff and two residents who use the laundry room confirms that residents know the door code or staff allows them to enter a non-residential area when they are not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are locked when residents are not supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :



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1. Licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the written plan of care for Resident #4 completed in April 2013 indicates resident to receive necessary physical assistance, extensive physical assistance, with transferring from one position to another, with mechanical lift or sit to stand lift, by two persons for constant supervision.

Review of the clinical record of Resident #4 indicates that in the second quarter of 2013 resident had a fall, during a transfer from wheelchair to bed. Interview with staff confirms resident was not constantly supervised by two persons while transferred, as required in the resident's plan of care. Resident was in the wheelchair besides the bed and the sling was under her body ready to be hung up on the lift. The lift was located at the end of the bed. While one staff was still with the resident, the other one went to the washroom to do some preparation for the resident personal care. When the second staff came back from the washroom, she\he heard noise from resident falling on the floor. Resident sustained a forehead laceration from the wheelchair foot rest.

[s. 6. (7)]

Issued on this 27th day of November, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

SLAVICA Vucko