Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2015	2015_321501_0019	030408-15	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

BENDALE ACRES
2920 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2T8

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600), SOFIA DASILVA (567)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 6, 9, 10, 12, 13, 16, 17, 19, 20, 23 and 24, 2015.

The following complaints and critical incidents were inspected concurrently: CSC #009978-14, #009743-15 and #025304-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Nursing, Nutrition Managers, Manager, Building Services, Registered Dietitian, Nurse Managers, Social Work Counsellors, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), Food Service Workers, cleaners, Residents' Council President, Family Council member, residents and Substitute Decision Makers (SDMs).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

16 WN(s)
8 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Based on the severity of the outcome for the resident, and the home's history with respect to failing to follow the plan of care related to falls prevention, a compliance order is warranted. On October 28, 2014, after the annual Resident Quality Inspection, a Voluntary Plan of Correction was given to the home but findings remain similar to the previous inspection.

Neglect, for the purposes of the Long-Term Care Homes Act and the Regulations, means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of the home's policy #RC-0305-00 titled "Zero Tolerance of Abuse and Neglect" last revised January 10, 2014, states "the Long Term Care Homes and Services Division will not tolerate the neglect of any resident by any person. Neglect is defined as any action or inaction by any person against a resident that the person knew or ought to have known, would cause harm to the resident's health, safety or well-being."

Review of an identified resident's progress notes revealed that on an identified date, the resident sustained a fall. The notes revealed that the resident was found on the floor. Review of the home's investigation notes revealed an identified PCA was providing care to the resident in bed. An identified RN had assisted with transferring the resident to bed using a lift. The RN then left the PCA on his/her own to care for the resident while he/she administered medications.

Review of the identified resident's most recent written plan of care, revealed the resident had a history of multiple falls and had a fall incident with no injury on an identified date. Strategies included the application of side rails while in bed and the addition of a fall out mattress on one side of the bed.

Review of the home's investigation notes and interview with the PCA revealed that the PCA had disengaged the side rail on the side where he/she was performing care and raised the bed height for comfort. Also, he/she revealed that the fall mattress was removed as they had just transferred the resident back to bed and they do not replace the fall mattress until they are finished their care. The identified PCA stated that he/she turned away from the resident to place an item on a ledge and in that time he/she heard a bang. He/she turned and found the resident on the floor. The PCA called the RN for assistance. Upon assessment, the RN decided to have the resident transferred to the hospital for further assessment. The resident sustained an injury.

Interview with the PCA revealed that the resident had a medical condition and was known to move while in his/her wheelchair and bed. The PCA confirmed that he/she turned away before ensuring that the resident was safe in the bed. Review of the investigation notes and interview with an identified Nurse Manager confirmed that staff are expected to ensure residents are safe before they step away, including side rails in place, mattress pad on the floor and bed in lowest position. The Nurse Manager confirmed the PCA did not ensure the resident was safe prior to turning away from the resident to set an item on the ledge. [s. 19. (1)]

2. A review of an identified resident's progress notes revealed that the resident suffered a fall on an identified date. This was not documented in the resident's progress notes until two days later. Progress note entries for two identified dates following the fall, revealed that the resident complained of pain and insomnia and refused to get up. The resident was sent to the hospital the day after the fall. The resident was diagnosed with an injury and passed away in hospital on an identified date.

Review of the home's investigation notes and interview with an identified RN revealed that the RN did not document or communicate with staff on the incoming shift regarding the resident's fall. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the of residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, is fully respected and promoted.

On November 16, 17, 20 and 23, 2015, the administration of medication was observed on three identified home areas. Medications administered to each resident were kept in their original pharmacy packages with the resident's name and room numbers. After the administration, the RPNs discarded the packages in the garbage bin which was set outside the medication cart.

Interview with two identified RPNs indicated the empty medication packages are collected in the garbage bin and thrown in the garbage disposal. An identified RPN indicated when registered staff perform medication destruction, they pour liquid over the packages to remove the residents' confidential information, but for empty packages, they just throw them in the garbage.

Interview with the DON confirmed the home does not have a process in place to protect the residents' personal health information from empty medication packages. [s. 3. (1) 11. iv.]

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 the of residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, is fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On November 9, 2015, observation on an identified home area revealed that a shower and tub room was left open and the floor in the shower area was wet with no wet floor sign. There were no staff members in sight. Interview with an identified RPN confirmed that this door should be closed and locked as the wet floor posed a risk for residents who could wander in, slip and fall. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care that sets out the planned care for each resident.

Review of an identified assessment record on two identified dates, revealed an identified resident had impaired skin integrity on three specific areas of the body.

The identified resident's most recent written plan of care did not include interventions for one of the specified areas of impaired skin integrity.

Interview with an identified RN revealed the resident experienced a recurring impaired skin integrity to one of the specified body areas over the past year. The impaired skin integrity opened again on an identified date and weekly assessments were started, however, the plan of care for this one specific impaired skin integrity was not included in the most recent written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of an identified resident's most recent written plan of care revealed the resident was at high nutritional risk related to weight loss, fair to poor intake and swallowing difficulties. The plan of care indicated the resident was to receive thickened fluids and a supplemental beverage at meals and at a specific nourishment time.

On an identified date, observation at a specific meal revealed the identified resident was served the supplemental beverage that was not thickened. Interview with an identified food service worker revealed the resident should have been served this beverage in a thickened form.

On the same day, observation at another meal revealed the identified resident was not served the supplemental beverage at all. Interview with an identified food service worker and the RD revealed that the resident had not been served the supplemental beverage as indicated on his/her plan of care.

Interview with the RD revealed that the identified resident needed to be served thickened beverages to prevent aspiration and supplemental beverages to address weight loss and poor intake. The RD confirmed that on the above mentioned date the identified resident was not provided the care as specified in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

On four identified dates, an identified resident was observed not wearing glasses.

Review of the resident's written plan of care and the most recent Minimum Data Set (MDS) assessment, indicated the resident had visual impairment and wears glasses.

Interview with an identified PCA confirmed the resident does not wear glasses and there were no glasses in the resident's room to indicate the resident needed them.

Interview with a family member indicated the identified resident had worn glasses when he/she was admitted to the home, but after a while due to a decline in cognitive status, he/she did not benefit from wearing glasses, so was not wearing them.

Interview with an identified RN confirmed resident used to wear glasses, but since his/her

cognitive status deteriorated and he/she did benefit from wearing glasses, he/she no longer wears them. The RN also confirmed that the written plan of care was not revised to reflect that glasses are no longer necessary. [s. 6. (10) (b)]

4. Review of the weekly assessment record on two identified dates, revealed an identified resident had three areas of impaired skin integrity.

The resident's most recent written plan of care, indicated one of the areas of impaired skin integrity had healed.

Interview with an identified RN confirmed this identified area of impaired skin integrity had reopened and confirmed the resident's written plan of care was not revised and updated after the resident was assessed on an identified date, to indicate the area of impaired skin integrity had reopened. [s. 6. (10) (b)]

5. Review of an identified resident's written plan of care indicated the resident was at high risk for impaired skin integrity due to skin which was prone to break down easy. It did not indicate the resident had any areas of impaired skin integrity.

Review of the resident's progress notes on an identified date, indicated an area of impaired skin integrity on an identified body area was open at this time.

Interview with an identified RPN revealed the resident had impaired skin integrity on an identified body area for some time. The RPN confirmed the written plan of care was not revised to reflect the change of resident's care needs after the skin broke down.

Interview with the DON confirmed the staff are expected to assess residents' skin on a daily basis while providing care and if changes occur, they are to review and revise the written plan of care. [s. 6. (10) (b)]

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 there is a written plan of care that sets out the planned care for each resident,
-to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and
-to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Review of the weekly assessment record on two identified dates, revealed an identified resident had three areas of impaired skin integrity.

The treatment record for an identified month, revealed the resident had treatment in place for only two areas of impaired skin integrity.

Interview with an identified RN revealed the resident experienced a recurring area of impaired skin integrity to an identified body area over the past year. The area of impaired skin integrity opened again on an identified date, and weekly assessments were started. The treatment record indicated no treatment had been provided for this identified area of impaired skin integrity.

Interview with an identified RN confirmed there was no treatment initiated when the area of impaired skin integrity re-opened on an identified date. [s. 50. (2) (b) (ii)]

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, a resident exhibiting altered skin integrity, including pressure ulcers receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program includes an annual resident satisfaction evaluation of continence care products in consultation with residents.

Record review of the continence care and bowel management program revealed an annual resident satisfaction evaluation of continence care products had been conducted in consultation with the direct care staff only and not with the residents.

Interview with an identified Nurse Manager, who is the lead for the continence care and bowel program, confirmed the home had not conducted an annual resident satisfaction evaluation of continence care products in consultation with the residents. [s. 51. (1) 5.]

2. The licensee has failed to ensure that the resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.

Review of the MDS assessment record, revealed an identified resident tended to be incontinent at various times and continent at other times. The written plan of care indicated the resident was totally dependent on staff for transfer and was toileted using a mechanical lift.

Interview with the identified resident indicated he/she was continent but was not always toileted due to the need to use a lift with two staff present, which was not always available as needed. On an identified date, when the resident was interviewed, he/she confirmed the PCA had just changed his/her incontinent product and was told he/she would not be toileted until an identified time when they put him/her in bed.

Interview with an identified PCA confirmed the identified resident was continent but was not toileted every time when he/she needed due to two staff not being available to use the lift. The PCA confirmed that on the above mentioned identified date, he/she only changed the resident's incontinent product and that normally the staff place the resident on the toilet only at an identified time when they put him/her in bed.

Interview with the DON confirmed the expectation in the home is that residents who have potential for continence but are unable to toilet independently, are assisted to manage and maintain continence. The DON further stated that not having staff available to use the lift is not acceptable. [s. 51. (2) (c)]

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 the continence care and bowel management program includes an annual resident satisfaction evaluation of continence care products in consultation with residents and that the resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes and a tracking table of follow up forms revealed that there were three issues that originated at the January 8, 2015, meeting as follows:
• Nursing staff shortage and replacement,
• Noise levels on the units at night, and,
• Concerns related to the service in dining rooms.
The follow up form and tracking table indicated that for the nursing staff shortage and replacement issue, the form was sent to the acting DON on January 13, 2015, but an action plan was not received by the council until January 30, 2015. Interview with the staff assistant to the Residents' Council confirmed that in this case, the home had not responded in writing within 10 days of receiving the concern.

Further review of the follow up forms and tracking table indicated that for the issues of noise levels on the units and concerns related to the service in the dining rooms, response forms were sent on January 13, 2015, and action plans were received on January 18, 2015. The responses were not accepted by the Residents' Council and the forms were resubmitted to the home on February 6, 2015. Response to the resubmitted forms did not take place until April 1, 2015. Interview with the staff assistant to the Residents' Council confirmed that in these cases, the home had also not responded in writing within 10 days of receiving concerns. [s. 57. (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 there is a response in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating.

The home's policy #RC-0523-04 titled "Assistance at Mealtime" updated January 9, 2013, states that those assisting residents with eating should sit down and be as close to the same height as possible to the resident while offering feeding assistance.

On an identified date, observations during lunch in an identified home area dining room revealed that four identified staff were not at the same height as the four identified residents they were assisting.

These above mentioned staff members were sitting on chairs that had been adjusted to a level that was much higher than that of the above mentioned residents. It was also observed that a private care giver was standing while feeding identified resident.

Interview with an identified nutrition manager revealed that these staff members should be sitting at eye level to assist residents with eating and attempted to provide training to these staff members during the meal service.

On an identified date, observation at breakfast on the second floor, revealed an identified PCA standing while assisting an identified resident. Interview with the PCA revealed he/she was aware that he/she should be sitting at eye level to assist residents with eating.

On the same day, observation at lunch on the second floor, revealed an identified PCA standing while assisting an identified resident. Interview with the PCA revealed an awareness that he/she should be sitting at eye level to assist residents with eating.

Interview with the RD confirmed staff should be sitting and be at eye level with the resident when assisting with eating. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On November 16, 2015, the administration of medication was observed on the fifth floor. Medications had been delivered by the pharmacy in individual plastic packages labelled with the resident's name, room number, time to be administered and name of the medication.

Observation of the medication cart drawers identified two unlabelled medication paper cups with medications placed together in a drawer where nursing supply items are kept.

Interview with an identified RPN revealed the medications belong to two different residents. One of the medications was kept in the paper cup because he/she dropped it in the morning and was going to discard it later. The other container had medications that he/she was not able to administer to the resident at 0800 hours, and wanted to attempt to administer at lunch time. The RPN confirmed he/she was not aware that medications should be kept in the original labelled container.

Interview with the DON confirmed the expectation in the home is for medications to be kept in labelled containers until they are administered to the resident. [s. 126.]

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 drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented.

Review of the written plan of care for skin integrity for two identified residents indicated staff are to change resident's position every two hours in bed and in chair using a positioning sheet to prevent shearing of skin, and to monitor resident's comfort level.

Review of both residents' medical records revealed there was no documentation whether these interventions occurred and what the residents' responses were.

Interview with two identified PCAs indicated there was no record for PCAs to document when they change residents' position and comfort level after repositioning. An identified PCA further indicated they use to have a form to sign after having turned and repositioned the resident, but now they no longer use it.

Interview with two identified RPNs confirmed PCAs do not document when they change the residents' position or response to that intervention but rely on them to perform these duties.

Interview with the DON confirmed that staff are expected to document their interventions and how residents respond to them. [s. 30. (2)]

2. A review of an identified resident's progress notes revealed that the resident suffered a fall on an identified date at an identified time. This was not documented until two days later. After the fall, on two identified dates, the resident complained of pain and insomnia and refused to get up. The resident was sent to hospital on an identified date for assessment. The resident was diagnosed with a fracture and passed away in hospital on identified date.

Review of the home's investigation notes and interview with an identified RN revealed that the RN did not document the resident's fall, including the post-fall assessment or any of the required components identified in the home's policy immediately following the incident.

Interview with the DON confirmed that the identified resident's fall and assessments were not documented. [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents receive mouth care in the morning and evening.

Interview with an identified resident revealed he/she does not always have assistance to brush his/her teeth in the evenings. Interview with an identified day PCA revealed the identified resident needs assistance with having his/her teeth brushed and his/her teeth do not always appear to have been brushed from the previous evening. Interview with an identified evening PCA revealed he/she does not always provide mouth care for the identified resident in the evenings.

Interview with an identified Nurse Manager confirmed it is the home's expectation that residents are provided mouth care twice daily, once during the day shift and once during the evening shift. [s. 34. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine is supported and individualized to promote comfort, rest and sleep.

Record review of an identified resident's written plan of care, revealed resident's waking time was an identified time in the morning.

Interview with the identified resident revealed PCAs would wake him/her up early in the morning to dress him/her for breakfast at 0800 hours. The resident indicated he/she had expressed to staff his/her preference to stay longer in bed in the morning, but the response he/she received was that he/she must be up for breakfast.

Interview with an identified PCA confirmed the resident is woken early in the mornings and assisted to get ready and attend the dining room, as they don't want him/her to miss breakfast.

Interview with an identified RPN confirmed the resident's sleeping plan is set based on the staff routine to be able to get every resident up for breakfast unless the night staff report that a resident did not have a good night's rest. [s. 41.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered at each meal.

On an identified date, observation at lunch revealed two identified residents were only served pureed meat and mashed potatoes as their entree. Review of the therapeutic menu revealed pureed chickpeas were to be included with this entrée.

Interview with an identified food service worker revealed pureed chickpeas were not available. Interview with the RD revealed pureed chickpeas were available and directed the food service worker to offer this menu item to residents who were to receive this pureed entrée.

Further observation revealed both identified residents consumed the pureed chickpeas after having been served this menu item.

Interview with the RD confirmed that during lunch on an identified date, the two identified residents were not offered all planned menu items until it was brought the home's attention by the inspector. [s. 71. (4)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report.

Review of Critical Incident Report (CIS), revealed that an identified resident had a witnessed fall in his/her room on an identified date. The resident suffered injuries to identified body parts. The resident was transferred to the hospital and returned to the home on the same day. The CIS was submitted four days later.

Review of the resident's progress notes revealed that the resident had a history of falls and had experienced multiple falls. Interview with an identified PCA and an identified RN revealed that the resident had a history of multiple falls, the vast majority of which had not resulted in hospitalization or injury.

Interview with the DON revealed that maybe, as a result of the weekend, the CI was submitted late, as the fall took place on a Friday. [s. 107. (3) 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On November 16, 2015, the inspector observed an identified RPN administering medication in front of the dining room. The RPN was administering medication to four residents and in between the administration he/she pushed the medication cart and pushed residents from the dining room to the hallway and back, or from their room to the medication cart. He/she applied breaks on the wheelchairs and administered medication to the residents. There was no hand sanitizer on the medication cart.

Interview with the identified RPN indicated he/she did not touch the medication so he/she did not find it necessary to wash his/her hands. However, he/she confirmed the home's expectation is to practise hand hygiene between each resident's medication administration.

Interview with the DON confirmed staff are expected to have hand sanitizers on each medication cart and to clean their hands using this sanitizer before and after giving medication to each resident. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection are recorded and that immediate action is taken as required.

Review of the written plan of care for an identified resident revealed the resident had a surgical procedure. Staff were to monitor and the goal was to have no infection. Review of the progress notes for the identified resident revealed that on an identified date, the resident was started on antibiotics for an infection. A review of the progress notes revealed the symptoms of infection were not documented on two identified dates and shifts.

Interview with an identified Nurse Manager revealed that registered nurses can use their judgment regarding when to document, as the resident's condition may be improving, but that best practice is to document on every shift. [s. 229. (5) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is created and maintained for each resident.

Review of an identified resident's progress notes revealed the resident had a fall on an identified date.
A review of the home's policy, titled, "Falls Prevention and Management" published January 8, 2013, stated, that after a resident has fallen, staff are to conduct a post-fall assessment huddle and complete a post-fall assessment huddle form.

Interview with an identified Nurse Manager revealed that a post-fall assessment had to have been
conducted, as an incident report (IR) had been filled out and the IR would not have been signed off without the post-fall assessment form attached to it. The Nurse Manager, however, was unable to locate a copy of the post-fall assessment huddle form for the fall on the above identified date.

Interview with an identified Nurse Manager confirmed that this record could not be found. [s. 231. (a)]

Issued on this 14th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600), SOFIA DASILVA (567)
Inspection No. / No de l'inspection :	2015_321501_0019
Log No. / Registre no:	030408-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 2015
Licensee / Titulaire de permis :	City of Toronto 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	BENDALE ACRES 2920 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-2T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARGARET AEROLA

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that all residents are not neglected by the licensee or staff.

The plan will include, at a minimum, the following elements:

-Education, including what constitutes neglect and inaction.
-A review of processes when providing care to the resident while the resident is in bed, specifically a review of safety procedures which must be completed before stepping away from residents who are at risk for falls.
-A review of the plans of care for residents with Parkinson's or other such health conditions that predispose them to erratic movement to ensure that the plans of care include adequate safety precautions.
-An audit process or another system for the ongoing monitoring of the required use of safety precautions or processes relating to provision of care of resident while in bed. This may include a plan that outlines the long-term monitoring of the resident safety while in bed, in wheelchairs, and shower chairs.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a timeline for achieving compliance, for each part of the plan.

Please submit the plan to Sofia.daSilva@ontario.ca no later than January 15, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Based on the severity of the outcome for the resident, and the home's history with respect to failing to follow the plan of care related to falls prevention, a compliance order is warranted. On October 28, 2014, after the annual Resident Quality Inspection, a Voluntary Plan of Correction was given to the home but findings remain similar to the previous inspection.

Neglect, for the purposes of the Long-Term Care Homes Act and the Regulations, means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of the home's policy #RC-0305-00 titled "Zero Tolerance of Abuse and Neglect" last revised January 10, 2014, states "the Long Term Care Homes and Services Division will not tolerate the neglect of any resident by any person. Neglect is defined as any action or inaction by any person against a resident that the person knew or ought to have known, would cause harm to the resident's health, safety or well-being."

Review of an identified resident's progress notes revealed that on an identified date, the resident sustained a fall. The notes revealed that the resident was found on the floor. Review of the home's investigation notes revealed an identified PCA was providing care to the resident in bed. An identified RN had assisted with transferring the resident to bed using a lift. The RN then left the PCA on his/her own to care for the resident while he/she administered medications.

Review of the identified resident's most recent written plan of care, revealed the resident had a history of multiple falls and had a fall incident with no injury on an identified date. Strategies included the application of side rails while in bed and the addition of a fall out mattress on one side of the bed.

Review of the home's investigation notes and interview with the PCA revealed that the PCA had disengaged the side rail on the side where he/she was performing care and raised the bed height for comfort. Also, he/she revealed that the fall mattress was removed as they had just transferred the resident back to bed and they do not replace the fall mattress until they are finished their care. The identified PCA stated that he/she turned away from the resident to place an

item on a ledge and in that time he/she heard a bang. He/she turned and found the resident on the floor. The PCA called the RN for assistance. Upon assessment, the RN decided to have the resident transferred to the hospital for further assessment. The resident sustained an injury.

Interview with the PCA revealed that the resident had a medical condition and was known to move while in his/her wheelchair and bed. The PCA confirmed that he/she turned away before ensuring that the resident was safe in the bed. Review of the investigation notes and interview with an identified Nurse Manager confirmed that staff are expected to ensure residents are safe before they step away, including side rails in place, mattress pad on the floor and bed in lowest position. The Nurse Manager confirmed the PCA did not ensure the resident was safe prior to turning away from the resident to set an item on the ledge. [s. 19. (1)]

2. A review of an identified resident's progress notes revealed that the resident suffered a fall on an identified date. This was not documented in the resident's progress notes until two days later. Progress note entries for two identified dates following the fall, revealed that the resident complained of pain and insomnia and refused to get up. The resident was sent to the hospital the day after the fall. The resident was diagnosed with an injury and passed away in hospital on an identified date.

Review of the home's investigation notes and interview with an identified RN revealed that the RN did not document or communicate with staff on the incoming shift regarding the resident's fall. (567)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

Service Area Office /
Bureau régional de services : Toronto Service Area Office