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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
May 19, Jun 7, 13, 2016	2016_396103_0015	002640-14, 000996-15, 002995-15, 013994-15, 019051-15, 021502-15, 030626-15, 032507-15, 035660-15	Critical Incident System

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 2-6, 9-13, 16-18, 2016

The following logs were included in this inspection: 002640-14 (alleged staff to resident abuse), 000996-15 (alleged resident to resident abuse), 002995-15 (resident fall), 013994-15 (alleged resident to resident abuse), 019051-15 (resident fall), 021502-15 (resident fall), 030626-15 (alleged resident to resident abuse), 032507-15 (alleged resident to staff abuse), 035660-15 (alleged staff to resident abuse), 019168 -15 (alleged staff to resident abuse), 014909-16 (missing resident), 013940-16 (alleged resident to resident abuse).

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Nurse Managers (NM), the Director of Care (DOC) and the Administrator.

The inspector conducted a full walking tour of the home, made resident observations, reviewed resident health care records, applicable policies, home's documented record of complaints and home's investigation notes related to the incidents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **0 VPC(s)**
- **0 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. 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The following finding relates to Log #002640-14:

The licensee has failed to ensure the care set out in resident #008's plan of care was provided to the resident as specified in the plan.

On an identified date, resident #008 was assisted to the bathroom by PSW #111. The resident was left unattended and later found by Maintenance worker #112 on the floor outside of the bathroom. The resident was assessed by the staff and sustained injuries as a result of the fall.

The resident health care record was reviewed and indicated resident #008 was assessed as high risk for falls and had sustained seven falls since admission .The resident care plan in effect at the time of the incident indicated the following:

"ADL assistance –Toileting":
Extensive assistance 1 staff
Staff must remain with resident while on toilet.

The home investigated the incident and the staff member received disciplinary action for failing to provide care as outlined in resident #008's plan of care. [s. 6. (7)]

2. The following finding relates to Log #002995-15:

The licensee has failed to ensure different approaches were considered for resident

#001 in the revision of the plan of care when care set out in the plan were not effective.

Resident #001 was admitted to the home on an identified date and was assessed as high risk for falls. The resident health care record was reviewed for an identified period of time and according to the progress notes, resident #001 sustained six falls during that period of time. Nurse Manager #105 was interviewed and indicated staff conducted post fall huddles to reassess the interventions in place to reduce the resident from having subsequent falls. The post fall huddles were reviewed with #105 and indicated interventions as follows:

- remind resident to lock wheelchair when reclining, staff to assist resident to position wheelchair at the dining table, assist resident with dressing and toileting in the morning, remind resident to call for assistance, call bell placed within reach, referral to physiotherapy, and assess resident frequently (no evidence of a specified time frame).

The above interventions were reviewed with the DOC. The inspector raised concerns that due to this resident’s impaired cognition, the interventions such as reminding the resident to call for assistance or lock the wheelchair prior to transfers or reclining were unrealistic as the resident would be unable to retain these instructions. Additionally, the interventions such as call bell within reach, assist resident with dressing and toileting, and assist resident to position the wheelchair at the dining room table were already strategies included in the resident’s plan of care and would be considered expectations of care.

The DOC agreed that these interventions did not reflect strategies to reduce subsequent falls and indicated the home addressed this in the recent fall management education.

Resident #001's current plan of care was reviewed and included the following strategies to reduce falls:

hi/lo bed, fall mat on the floor, proper foot wear and provide prompt assistance when resident wakens to avoid self transfers. PSW staff were interviewed and were knowledgeable of the fall prevention strategies in place at this time for resident #001.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The following finding relates to Log #002995-15:

The licensee has failed to ensure the policy required under O. Reg 79/10 s. 49 (1) which states, the falls prevention and management program must provide for strategies to reduce or mitigate falls, including the monitoring of residents was complied with.

The home has a head injury routine policy, titled, "Suspected Head Injury", RC-0518-20. This policy was reviewed and indicated under "Purpose", to provide early detection of changes in intracranial pressure.

Under, "Procedure" the policy indicated, when residents sustain any head trauma, initiate Head Injury Routine (HIR) for 24 hours or as per physician's order. The procedure further indicated to assess and document:

-level of consciousness
-vomiting that continues or worsens
-difficulty breathing
-headache
-TPR and BP
-pupil reaction and size
-changes in behaviour.

As outlined in WN #1, resident #001 sustained a number of falls. Staff initiated the head injury routine (HIR) following the two falls sustained on identified dates. The documentation of the head injury monitoring was reviewed by this inspector.

Throughout the assessment period, staff failed to indicate the resident's level of consciousness, pupil reaction and size. There was no documentation to suggest the resident may have refused this portion of the assessment and there were no physicians orders related to the completion of the HIR. The Head injury routine monitoring for resident #001 was discussed with the Director of Care. She indicated staff are expected to fully assess the resident in accordance with the policy to assess for possible increasing intracranial pressure.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The following finding relates to Log# 002640-14, Log# 030626-15, and Log# 019168-15:

The licensee has failed to ensure the home's zero tolerance of abuse policy was complied with.

According to O. Reg 79/10, s. 5, neglect is defined as 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.

On an identified date, an alleged incident of staff to resident abuse/neglect occurred involving resident #008 as outlined in WN #1. The resident sustained injuries as a result of the incident. The home submitted a critical incident to the MOHLTC to report the incident six days later and notified the police of the alleged incident eight days after the incident occurred. Resident #008's SDM was never notified of the alleged abuse, only that the resident had sustained a fall.

The legislation requires that the long term care home must have a written policy to promote zero tolerance of abuse that complies with all legislated requirements and that the policy is complied with. The home's abuse policy titled, "Zero Tolerance of Abuse", RC-0305-00 was reviewed. The home failed to follow their abuse policy in the incident involving resident #008 as follows:

Failure to immediately notify the MOHLTC of the alleged staff to resident abuse: The policy under "Procedure" states, notify the MOHLTC immediately that an alleged, suspected or witnessed incident of abuse or neglect has become known and an investigation is underway.

Failure to immediately notify the police of the alleged staff to resident abuse: The policy under "Procedure" states, immediately notify the police of any alleged, suspected or witnessed incidents of abuse or neglect of a resident that may constitute a criminal offence.

Failure to notify the substitute decision maker (SDM) of the alleged abuse and the home's intention to investigate the allegation. [s. 20. (1)]

2. According to O. Reg 79/10, s. 2 (1), physical abuse is defined as the use of a physical force by a resident that causes physical injury to another resident.

On an identified date, an alleged incident of resident to resident abuse occurred involving residents #009 and #010. Resident #010 sustained an injury as a result of the incident. The home notified the MOHLTC of the alleged abuse for the first time by submitting a critical incident five days after the incident. In addition, the resident progress notes indicated the family declined to have the police notified of the alleged abuse. The requirement to notify the police of all suspected, alleged or witnessed incidents of abuse

and neglect that constitute a criminal offence is a legislated requirement and does not require family consent.

The home also failed to report the outcome of their investigation into the alleged physical abuse of resident #010 to the MOHLTC upon completion of their investigation. The home's abuse policy under "Preamble" states, "the results of the investigation and action taken must be reported to the MOHLTC through the Critical incident system". [s. 20. (1)]

3. On an identified date, resident #011's family member approached RN #109 and reported concerns in regards to the care the resident was receiving from PSW #114. RN #109 was interviewed and indicated the family made allegations of neglect and abuse during the conversation. The RN stated she removed the PSW from caring for the resident at that time and felt the concern had been resolved. RN #109 further stated she is aware she should have followed the home's abuse policy and immediately reported the incident to the MOHLTC. The home informed the MOHLTC for the first time of the incident of alleged abuse by means of submitted a critical incident seven days later. [s. 20. (1)]

4. The following finding relates to Log # #002640-14, and Log# 030626-15:

The licensee has failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of residents complies with all legislated requirements.

The home's abuse policy titled, "Zero Tolerance of Abuse and Neglect", RC-0305-00, updated on 01-10-2014 was reviewed by this inspector. Under "Procedures", the policy indicated within 4 hours of becoming aware of an incident of abuse/neglect, notify the family or substitute decision maker (SDM) of the resident(s) involved. This is contrary to the legislation, O. Reg 79/10 s. 97 (1) which states:

Every licensee of a long term care home shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged,

suspected or witnessed incident of abuse or neglect of the resident. [s. 20. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The following finding relates to Log# 035660-15 and Log# 019168-15:

The licensee has failed to ensure written letters of complaints concerning the care of a resident or the operation of the long-term care home were immediately forwarded it to the Director (MOHLTC).

On an identified date, the Administrator received a verbal complaint from resident #007's family alleging resident personal property had been damaged during an alleged staff to resident abuse. The Administrator requested this complaint be put into writing. The family emailed the Administrator approximately six weeks later outlining the same concerns as expressed in the original verbal complaint. The Administrator failed to immediately forward the letter of complaint which included allegations of a resident assault.

On an identified date, the family of resident #011 submitted a written letter of complaint that included allegations of staff to resident verbal abuse. This letter was not forwarded to the Director until twelve days later. [s. 22. (1)]

WN #5: 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 following finding relates to Log #019051-15:

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.

On an identified date, resident #002 was observed by a staff member to fall and strike their head. The resident health care record was reviewed by this inspector and indicated the home initiated head injury routine (HIR) to monitor the resident post fall. The inspector was unable to locate this assessment and the home was directed to produce the assessment. Nurse Manager #108 was interviewed and indicated she was unable to locate the documentation of the HIR assessment but believed the assessment had been completed. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The following finding relates to Log #035660-15:

The licensee has failed to ensure every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response is made within 10 business days outlining what has been done to resolve the complaint or why the licensee believes the complaint to be unfounded and reasons for the belief.

As outlined in WN #6, the home received a verbal complaint on an identified date. The home responded to the complaint in writing with a letter dated two months following the verbal complaint. [s. 101. (1) 1.]

2. The following non-compliance relates to Log #035660-15:

The licensee has failed to ensure a verbal or written complaint was included in the home's documented record of complaints.

The home's documented record was reviewed for an identified period of three months. As outlined above, the verbal complaint made by resident #007's family which was received by the Administrator on an identified date and the email letter of complaint with an identified date were not included in the home's documented record of complaints. [s.101. (2)]

WN #7: 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 following finding relates to Log #019051-15 and Log #021502-15:

The licensee has failed to ensure the Director (MOHLTC) was informed of an incident within one business day that caused an injury to a resident and resulted in a significant change in the resident's health condition.

On an identified date, resident #002 sustained a fall which resulted in a significant change in the resident's health condition. The home submitted a critical incident fifteen days after becoming aware of the significant change. [s. 107. (3) 4.]

2. On an identified date, resident #003 was found with unexplained injuries that resulted in a significant change in the resident's health condition. The home notified MOHLTC by submitting a critical incident seven days after becoming aware of the resident`s significant change in condition. [s. 107. (3) 4.]

Issued on this 7th day of June, 2016

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

Original report signed by the inspector.