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

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

Public Copy/Copie du public

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 9, 2016	2016_396103_0017	006574-15, 018659-15, 034651-15	Complaint

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 Complaint inspection.

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

The following intakes were included in this inspection: 006574-15 (complaint concerning resident care), 018659-15 (critical incident related to complaint 006574-15; alleged staff to resident abuse), 034651-15 (complaint regarding alleged staff 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:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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).

Findings/Faits saillants :

1. The following finding relates to Log #006574-15 and #034651-15:

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

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

On an identified date, an alleged incident of staff to resident abuse occurred involving resident #001. A family member of the resident approached RN #101 and alleged PSW #104 had physically abused the resident during the provision of care. RN #101 and #102 assessed the resident and reassigned the PSW.

RN #102 left a note for the Nurse Manager requesting she follow up on her next working day. The staff did not immediately notify the MOHLTC or the police of the alleged abuse. The family member notified the police later that same day.

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 #001 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. [s. 20. (1)]

2. On an identified date, the family of resident #002 sent an email to the Administrator alleging staff abuse. The MOHLTC was notified of this alleged abuse for the first time ten days later. Additionally the police were never notified of the alleged abuse because the home's documentation indicated the family declined. The immediate notification of the police for all alleged, suspected or witnessed incidents of abuse and neglect is a legislated requirement and does not require family consent. [s. 20. (1)]

WN #2: 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 #034651-15:

The licensee has failed to ensure a written complaint concerning the care of a resident or the operation of the long term care home was immediately forwarded to the Director (MOHLTC).

On an identified date, the Administrator received an email that included allegations of staff to resident abuse involving resident #002. This letter was never forwarded to the Director. [s. 22. (1)]

Issued on this 19th day of May, 2016

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

Original report signed by the inspector.