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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 14, 2018	2018_594624_0006	004497-18	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

BAIYE OROCK (624), JOVAIRIA AWAN (648), ROMELA VILLASPIR (653), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 5-9, 12-16, and 19-22, 2018

The following complaints and Critical Incident Reports (CIR) intakes were completed in this RQI Inspection:
Complaints-
Log #003516-18 related to falls prevention
Log #025453-17 related to nutrition and hydration concerns

Log #025847-17 related to continence care, and
Log #026659-17 - related to allegations of abuse and neglect.

CIR-
Log #002346-18, CIR #M504-000004-18 related to falls prevention,
Log #024238-7, CIR #M504-000053-17 and log #028943-17, CIR #M504-000061-17 related to allegations of resident abuse, and
Log #024797-17, CIR #M504-000052-17 related to an injury with significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the General Manager and the Director of Long Term Care Services at the City of Toronto, Nurse Managers, Nutrition Managers, a Registered Dietitian(RD), Physiotherapists (PT), an Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), a Behavioral Support Ontario (BSO) Worker, Personal Support Workers (PSWs), a Recreation Services Assistant (RSA), a Rehab Assistant (RA), presidents of Family and Residents' Council, family members and residents.

A tour of the home was completed and observations were made of resident to resident interactions, staff to resident interactions during care provision, and medication administration. A review was also completed of residents' health records, medication incidents reports, the licensee's internal investigation records, Residents'/Family Council meeting minutes, Professional Advisory Committee (PAC) meeting minutes as well as relevant policies and procedures related to nutrition and hydration, falls prevention, medication administration, minimizing of restraints, zero tolerance of abuse and neglect, and management of skin and wounds.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **7 WN(s)**
- **5 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to resident #025 as specified in the plan of care.

A complaint was submitted to the Ministry of Health and Long-Term Care on a specified date in 2017, indicating that staff are not providing care to resident #025 in a timely manner, related to a specified care device.

A review of resident #025's written plan of care last updated on a specified date, indicated that the resident was admitted into the home on a specified date. As per the completed review related to the specified care device, resident #025's written plan of care directed staff to wash, clean and change the resident's care device as needed and to empty/change the device when it was at a particular level.

On a specified date and time, Inspector #624, together with RPN #116 observed resident #025's care device to be full and above the specified level that required changing. In an interview with RPN #116 during the observation, the RPN confirmed the care device was full and above the particular level requiring changing. The RPN further indicated that as per the resident's plan of care, the care device should have been emptied/changed. The RPN proceeded to change the care device.

In separate interviews with RPN #109, PSW #113 and RN #114, all indicated that as per the resident's plan of care, the care device should be emptied/changed when it is at a particular level.

In an interview with the Nurse Manager (NM) #101 on a specified date after the observation above, the NM indicated that care should be provided to residents as specified in the plan of care. In the case of the above observation, they indicated that care was not provided as specified in the resident's plan of care.

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented related to falls preventions interventions for resident #024.

Complaint log #003516-18 was received by the MOHLTC on a specified date in 2018 related to resident #024's care in the home. The concerns were as follows:
-The resident had a number of falls with one particular fall resulting in a specified injury.

The resident was noted to sustain another fall about a month after the fall leading to injury.

Review of the high risk for falls section under resident #024's written plan of care revealed the resident was at high risk for falls and staff were to document an identified monitoring schedule for two weeks.

A review was completed by Inspector #653 of resident #024's monitoring record sheets over the two week period. This completed review revealed missing documentation between 1600 to 2200 hours on 10 separate days during the observed two week period.

A review of the staff schedules identified PSW #127 as the primary care giver for resident #024 who worked the evening shifts on the above mentioned dates. In an interview with PSW #127, the PSW confirmed their awareness of the scheduled monitoring for resident #024, and further indicated that they monitored the resident but did not have the time to document on the monitoring record sheets.

In an interview with Nurse Manager (NM) #101, after reviewing the documentation with the inspector, NM #101 confirmed that the staff did not document care that had been provided on the above mentioned dates.

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
1) the care set out in the plan of care is provided to the resident as specified in the plan, and
2) the provision of care set out in the plan of care is documented, to be implemented voluntarily.

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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

O. Reg 79/10, s. 30 (1). Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral to specialized resources where required.

O. Reg. s 48 (1). Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

A review of the home's skin and wound care program policy by Inspector #624, entitled, Skin Care and Wound Prevention, policy #RC-0518-02, published April 01, 2016, indicated:
Under Procedure:
11. Refer the resident to the skin care coordinator for follow up as indicated. Notify him/her if the area of altered skin integrity deteriorates or new areas develop and implement recommendations.
Under Treatment Protocol C: (Stage 3 and 4)
"1. Refer the resident to the Skin Care Coordinator for follow up with unit teams."

During the Resident Quality Inspection (RQI) stage 1, skin and wound care concerns were triggered for resident #005.

Resident #005 was admitted into the home on a specified date with specified diagnoses. A review of a specified health record of resident #005 indicated that on a specified date, the resident was noted to have a specified skin integrity issue at a specified location and the skin issue had been assessed and its presentation documented. A month later, the presentation of the same integrity issue was noted to have increased. Three months later, the presentation of the same skin integrity issue was noted to have further increased.

During the above mentioned period when the skin integrity issue of resident #005 was noted to have deteriorated, there was no indication a referral was made to the Skin Care Coordinator nor was there any indication the Skin Care Coordinator made any follow up with the unit teams as specified in the policy.

During RQI stage 1, skin and wound care concerns were also triggered for resident #006.

Resident #006 was admitted into the home on a specified date with specified diagnoses. A review of the resident's specified health record between a three month period, indicated that the resident had specified skin integrity issue at a specified body part. As per the same reviewed health record, by the end of the first month, the resident's skin integrity issue was noted to deteriorate to a stage higher. A month later, resident #006's skin integrity issue noted to have deteriorated further to a stage higher than the previous.

A review of resident #006's health records was completed for the same three month period identified above and indicated that a referral was not completed to the Skin Care Coordinator until the third month when the skin integrity issue was two stage higher than was identified at the beginning of the first month in the three month review period.

In separate interviews with RN #111 and RPN #112, related to skin and wound issues, both indicated that when a resident has a specified skin integrity issue, it is the licensee's expectation that weekly skin assessments are completed using a specified tool. As per both RPN #112 and RN #111, if the skin integrity issue does not improve, deteriorates or if new skin issues develop, the licensee's expectation is that registered staff will make a referral the Skin Care Coordinator.

In an interview with the Skin Care Coordinator, Nursing Manager (NM) #119, on a specified date and time, the NM indicated that when there is a deterioration of a skin issue or new skin issues develop, registered staff complete a referral to the Skin Care Coordinator. Related to resident #005, the Skin Care Coordinator was unable to tell whether or not a referral was ever made during the identified three month review period. The Skin Care Coordinator was unable to provide any referrals completed for resident #005.
Regarding resident #006, the Skin Care Coordinator indicated that the only referral they received was one made three months after the start of resident #006's skin integrity issues.

The licensee failed to comply with its Skin and Wound Policy by not ensuring that referrals were made to the Skin Care Coordinator when there was a deterioration in identified skin integrity issues related to resident #005 and resident #006.

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 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, (b) is complied with, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

On March5, 2018, Inspector #604 conducted an initial tour of the home. The following observations and interviews were carried out with the home's staff and management:

-On a specified resident home area at 1005 hours, the Inspector observed an open door labeled "Tub Room." The inspector did not observe any staff in the room, and the tub room door was equipped with a key pad. The floor of the tub room was wet and the room consisted of three other connected rooms: tub room, toilet, and a stand up shower area. The inspector also observed a small plastic cupboard consisting of multiple nail clippers in individual draws with room numbers. The inspector went out to the hall and did not observe any staff in the area, resident #001 approached the inspector and indicated they were going into the tub room to look. The inspector observed the resident was wearing a specified monitoring device and attempted to redirect the resident but the resident was persistent on going in to the tub room. The inspector pulled the call bell located in the tub room, and went back to the hall keeping the resident engaged in conversation. Shortly after PSW #103 arrived and then RPN #102 followed. The RPN spoke to resident #001 and walked the resident up the hall while the PSW stayed with the inspector.

Interviews were conducted at 1011 hours, with PSW #103 and RPN #102, and both staff members acknowledged the tub room door had been left open and accessible to anyone. The PSW and RPN stated the tub room door is to be locked when the room is not in use and it was not a resident area. The staff indicated there would be a risk of a fall if a resident wandered into the room and also had access to sharps such as the nail clippers.

An interview was conducted at 1415 hours with Nurse Manager (NM) #100. The NM stated that they were the NM responsible for the third and fifth floors. The NM stated that the tub room doors are to be locked at all times when the room is not in use or monitored due to the wet floors and accessibility of sharp items.

-On a second specified resident home area, at 1026 hours, the inspector found a door labeled "Clean linen" to be ajar. When the inspector pushed the key padded door it opened. PSW #104 confirmed to the inspector that the door was ajar and that the door did not lock when closed. When the Inspector and PSW entered the clean linen room the room consisted of staff lockers, staff personal items, two linen carts and a door to the right.

Interviews were conducted at 1030 hours with PSW #104 and RPN #105 who acknowledged that the clean linen room door was unlocked. The staff indicated the clean linen room was not a resident area and the door is to be locked at all times. The RPN stated leaving the clean linen room door posed a risk for residents as they may get locked in the room and may wander into the sprinkler valve room.

-On the second specified resident home area, at 1033 hours, the Inspector pushed a key padded door labeled "Soiled Utility" room and the door opened and when the door was let go the door did not lock. RPN #105 acknowledged the soiled utility room door was not locked and did not lock. The RPN and the inspector went into the room which consisted of an ARJO Ninja bed pan washer. The bottom door consisted of ARJO Sure Wash chemical. The RPN opened the top door of the ARJO Ninja which consisted of a sprayer pointed towards the door of the washer.

An interview was conducted at 1038 hours with RPN #105 who acknowledged the soiled utility room had been unlocked and the room was to be locked at all times. The RPN stated the room was not a designated resident area and the soiled utility room posed a risk to residents if they entered, due to accessibility of cleaning chemicals.
An interview was conducted at 1440 hours, with NM #101 who stated the clean linen and solid utility room doors are to be locked at all times when not in use. The NM stated these areas are not resident areas and the doors being left unlocked posed a risk of fall, ingestion of chemicals from the ARJO washer, and risk of injury if residents wandered into the room.

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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

The licensee has failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program were readily available at the home.

Complaint log #003516-18 was received by the MOHLTC on a specified date in 2018 related to resident #024's care in the home. The concerns were as follows:
-The resident had a number of falls, including a fall on a specified date resulting in an injury, followed by a subsequent fall a month later.

A review of the high risk for falls section under resident #024's written plan of care done a month after the last fall, revealed that the resident had the two falls above and one a month later, with no injuries.

Review of resident #024's referral form to the Occupational Therapist (OT) completed after the fall resulting in an injury, revealed that the resident was sent to the hospital and returned with an injury to a specified body part. A further review of the response section on the referral form, suggested that a specified intervention be put in place. The referral form was returned to the staff on a specified date. Review of the OT's progress notes on the date the referral form was returned to staff, indicated that the resident may benefit from the specified intervention to reduce risk of injury.

In an interview with the OT, the OT confirmed they had recommended and requested the specified intervention for resident #024 on the day the form was submitted to staff. The OT stated that they had informed the nurse manager, who had indicated they would follow-up on the requested intervention.

Interviews held with the PSWs and the registered staff in resident #024's home area stated that the specified intervention had not been available for use in the home.

Review of the home's policy titled "Falls Prevention and Management" #RC-0518-21, published January 10, 2016, indicated under environmental considerations that the interdisciplinary team will explore the use of the specified intervention for residents who would benefit from its use.

In separate interviews with the OT #138, PT #127, and NM #101, all acknowledged the above mentioned information and confirmed that the specified intervention had not been available in the home as required.

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 equipment, supplies, devices and assistive aids for falls prevention and management are readily available at the home, to be implemented voluntarily.

WN #5: 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 :

The licensee has failed to ensure that the Director is informed within one business day of an incident that causes an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A Critical Incident Report (CIR) was submitted to the Director on a specified date. According to the submitted CIR, on a specified night, resident #028 had requested an identified medication and was found with an injury to a specified body part. Resident was sent to hospital the following day and returned to the home on the same day, with a specified diagnosis.

In separate interviews with Nurse Manager (NM) #101, and the Administrator, both indicated that the Director should have been notified within one business day and that in this case, the report was submitted later than one business day.

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 Director is informed no later than one business day of any incident that occurs in the home, that causes an injury to a resident for which the resident was taken to a hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm to the resident.

A Critical Incident Report (CIR) was submitted to the Director on a specified date. According to the submitted CIR, the Director of Nursing (DON) had received a forwarded voice message from the Divisional Manager in which resident #029 had alleged abuse by staff. As per the CIR, the voice mail was played to Nurse Manager (NM) #101 in the DON's office. The CIR indicated that the DON and NM #101 interviewed resident #029 about the alleged abuse on a specified date. This allegation of abuse was not submitted to the Director until two days after the NM and DON spoke to the resident.

A review of the progress note of resident #029 revealed a documented entry indicating that the DON and NM #101 had both listened to the voicemail alleging abuse and spoke to resident #029 about the allegation two days before the CIR was submitted to the Director.

In separate interviews with NM #101 and the Administrator, both indicated that the licensee's expectation is that all alleged or witnessed incident of abuse shall be reported immediately to the Director. Both indicated this incident was not reported immediately to the Director.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

The licensee has failed to ensure that it sought the advice of Family Council in acting on the results of the satisfaction survey.

In an interview with the Family Council (FC) Chair on a specified date and time, the FC Chair indicated that when the results of the satisfaction survey are out, FC gets the results delivered to them but that the licensee does not seek their input or ask if they have any advice on acting on the results of the satisfaction survey.

In an interview with the Administrator of the Home on a specified date, the Administrator indicated that when the results of the satisfaction survey are received by the home, the management team meets and reviews problem areas and plans how to solve the identified problems. The administrator also indicated that management will act on the results of the satisfaction survey before they get a chance to meet with FC. The administrator further indicated that an update is provided to the FC about any changes implemented and seek their input, if there are any.

Issued on this 29th day of May, 2018

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

Original report signed by the inspector.