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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2019	2019_414110_0006	002236-19, 008426-19	Complaint

Licensee/Titulaire de permis

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

DIANE BROWN (110)

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): April 11, 12, 16, 17, 18, 23, 25, 26, 29, 30. May 1, 2, 10, 2019.

During the course of the inspection, the following complaint intakes were inspected related to resident's right to meet privately with a person.

During the course of the inspection, the inspector reviewed clinical health records, and correspondence relevant to the inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Administrator, the Nurse Manager Operations, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Social Worker (SW), Ministry of Health, Long Term Care Home inspector, and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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

- **1 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	Légende 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. 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:
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's right to meet privately with his or her spouse or another person in a room that assures privacy is fully respected and promoted.

The Ministry of Health and Long Term Care received a complaint on an identified date, that an identified person was unable to visit resident #001 in an area that ensured privacy. A subsequent complaint was also received.

A record review and interview with PSW #109 and Nurse Manager #102 indicated resident #001 was admitted to the home in an identified year and had regular visits with an identified person.

An interview with PSW #109 and RPN/BSO #108 shared that resident #001's visitor visited often, they had a close relationship and visits were in an area that ensured privacy.

An interview with Administrator #105 and a record review revealed that on an identified date the Administrator was presented with a situation causing them to consider the resident's safety as it related to the identified visitor. At this time, the Administrator imposed a restriction whereby the resident's identified visitor was unable to visit resident #001 in an area that ensured privacy.

A record review identified the resident's cognitive performance score as moderate impairment. The records identified that the resident has a Substitute Decision Maker (SDM) for care but a capacity assessment to determine competency had not been completed.

An interview with Administrator #105 revealed they were not aware if anyone had discussed the restrictions with the resident and an interview with Nurse Manager #102 confirmed they had not provided the resident with the opportunity to be asked if they would like to meet privately with the identified person.

The licensee has failed to ensure resident #001's right to meet privately with an identified person, in a room that assured privacy, was fully respected and promoted. [s. 3. (1) 21.]

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.