Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 22, 2020	2020_832604_0003	017851-19, 023137-19, 024217-19, 024219-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 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

SHIHANA RUMZI (604), ANGIEM KING (644)

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): January 9, 10, 13, 14, 15, 16, and 17, 2020.

During this inspection Critical Incident System (CIS) reports where inspected related to falls and abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Nurse Manager of Operations (NMO), Registered Nurses (RN), Registered Practical Nurses (RPN), Behaviour Support Services (BSS/BSO), and Nutrition Manager (NM).

During the course of the inspection, the inspectors conducted observations of staff and resident interactions, provision of care, conducted reviews of resident health records, home's critical incident log, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

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 :

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The home submitted a Critical Incident System (CIS) report indicating resident to resident abuse had occurred between resident #002 and #003 in an identified area of the home. The CIS report indicated Registered Practical Nurse (RPN) was conducting rounds and noted resident #003 was not in an identified location and heard screaming coming out of an identified area of the home. The RPN intervened found and found resident #003 abusing resident #002 in an identified location of the home. Resident #002 had stated to the RPN resident #003 abused them.

A review of resident #003's documentation consisted of identified intervention related to monitoring an identified resident equipment by staff. Further review indicated a "Monitoring Record" sheet for the identified resident equipment consisted of no documentation as per the set plan of care for identified dates and times.

In separate interviews with Nurse Manager of Operations NMO #100 and Registered Nurse (RN) #105, stated identified resident equipment were to be checked by Personal Support Work (PSW) or registered staff to ensure they are in working order and a sign-off sheet/"Monitoring Record" sheet was to be signed. The NMO and RN reviewed resident #003's "Monitoring Record" sheet and acknowledged there was no signatures on dates identified and times and care was not documented as indicated in the plan of care for resident #003.

2. The sample was expanded as areas of non compliance was identified related to resident #003's set plan of care was not followed as specified in the plan.

On an identified home area Inspector #604 and RN #105 carried out observation for an identified resident equipment for two other residents with "Monitoring Record" sheets. It was noted resident #004 and #005's "Monitoring Record" sheets had no signatures on the dates and times identified and care was not documented as indicated in the plan of care for residents.

A review of resident #004 and #005's documentation review consisted of identified interventions related to monitoring an identified resident equipment by staff. The plan of care consisted of a focus related to an identified responsive behaviour for resident #005.

In separate interviews with NMO #100 and RN #105 reviewed resident #004 and #005's

documentation and “Monitoring Record” sheet for an identified time period. The NMO and RN acknowledged there was no signatures on the dates and times identified above and care was not documented as indicated in the plan of care for resident #004 and #005.

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 provision of the care set out in the plan of care was documented, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure the resident was protected from abuse by anyone.

The definition of “abuse” in subsection 2 (1) of the Regulation "sexual abuse" means, subject to section (2), (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. O. Reg 79/10 s. 2 (b).

The home submitted a Critical Incident System (CIS) report indicating resident to resident abuse had occurred between resident #002 and #003 in an identified area of the home. The CIS report indicated Registered Practical Nurse (RPN) was conducting rounds and noted resident #003 was not in an identified location and heard screaming coming out of an identified area of the home. The RPN intervened found and found resident #003 abusing resident #002 in an identified location of the home. Resident #002 had stated to

the RPN resident #003 abused them.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect", #RC-0305-00, with a published date as of January 8, 2016, indicates one of the purposes for the policy is to prevention incidents of resident abuse and neglect. The policy includes behaviour or remarks of sexual nature towards the residents that are unwanted by the resident, including remarks that are sexually demeaning, humiliating, exploitative or derogatory as example of sexual abuse. (pages 1-10).

A review of resident #002's Minimum Data Set (MDS) assessment for an identified date, indicated the resident has cognitive loss.

A review of resident #003's MDS assessment indicated the resident had cognitive loss. A review of the resident's plan of care for an identified period consisted of a focus related to an identified responsive behaviour with interventions.

A review of resident #003's documentation was carried out for an identified period which indicated identified responsive behaviour incidents .

During an interview RPN #101 stated they worked on an identified date and home area and stated they did not observe resident #003 in an identified area of the home and heard resident #002 call out of help, and found resident #003 with resident #002. The RPN stated they observed resident #003 abuse resident #002 and further stated they intervened and told resident #003 to leave the identified home area and called for other staff for assistance. The RPN stated resident #002 was upset and indicated resident #003 abused them. The RPN further stated they considered this incident to be abuse and observed resident #002 to be scared, afraid, emotional, and did not feel safe.

In an interview RN #105 indicated they knew resident #003 presented with identified responsive behaviours and interventions where in place to address the residents identified responsive behaviours. The RN stated they worked on an identified date and stated they heard RPN #101 call out for help and the RN went to assist the RPN. The RN stated they heard resident #002 voice to the RPN that resident #003 abused them and noted resident #002 to be upset about the incident. The RN further stated they considered the incident to be abuse from resident #003 towards resident #002 and in closing stated resident #002 was competent and if the resident stated resident #003 abused them it would be a factual statement.

During an interview NMO #100 stated they where called to an identified unit and was informed incident of abuse had occurred between resident #002 and #003. The NMO stated resident #002 did not want to talk with the NMO related to the incident and observed the resident to be upset. The NMO stated if resident #002 made a statement indicating they where abused by resident #003 the comments would be factual and considered this incident to be abuse by resident #003 towards resident #002. The NMO stated the home failed to protect resident #002 from abuse from resident #003.

The licensee was issued a Compliance Order (CO) #001 related to s. 19 (1), on an identified date and report and a Written Notification (WN) is being issued following this inspection.

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.