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
Oct 28, 2020	2020_838760_0026	006718-20, 008850-20, 009084-20, 014091-20, 015772-20, 016136-20, 016269-20, 017378-20, 017654-20, 020467-20	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

JACK SHI (760)

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): October 14, 16, 19, 20, 21, 22, 23, 2020.

The following intakes were completed in this critical incident inspection:

Two logs were related to an allegation of resident abuse;
One log was related to an injury from a restraint;
Seven logs were related to falls.

During the course of the inspection, the inspector(s) spoke with the Occupational Therapist (OT), the Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Nurse Managers (NM) and the Director of Care (DOC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 and #007 were assessed in accordance to evidence based practices related to their use of bed rails.

A Critical Incident Systems (CIS) report was submitted by the home related to an injury that resident #006 sustained. Staff did not know at that time what caused their injury. The resident was then assessed further and diagnosed with a condition. An investigation was conducted and determined that the injury may have been related to the resident's bed rail. The home’s policy related to the use of bed rails indicates that an assessment tool is to be used before a resident receives a bed rail. The OT indicated that they could not find the assessment tool used by the home’s previous OT, when the resident first had their bed rail. There was actual harm to resident #006, as they sustained an injury from their bed rail and an assessment tool was not used at the time that they were provided with their bed rail.

Sources: Resident #006’s progress notes; the home’s investigation notes; Bed rail Use for Resident Self Mobility Policy (last updated: January 5, 2015); Interviews with the OT and other staff. [s. 15. (1) (a)]

2. Resident #009 was identified to have a bed rail. A review of the resident’s chart could not produce an assessment tool related to this resident’s use of a bed rail. The resident did not recall when they were last assessed by a registered staff related to their use of a bed rail. The RPN was unable to produce an assessment tool related to the resident’s use of their bed rail. There was potential risk of harm to resident #009, as they have not been assessed to determine whether their use of a bed rail would be considered safe.

Sources: Resident #009’s chart, care plan; Bed rail Use for Resident Self Mobility Policy (last updated: January 5, 2015); Interviews with the resident, an RPN and other staff. [s. 15. (1) (a)]

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 bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe positioning techniques when they provided care to resident #001.

A CIS report was submitted by the home regarding a fall that resident #001 sustained and resulted in a diagnosed injury. A review of the resident's progress notes indicated that a PSW was providing care to the resident. The PSW then turned around to get an item for the resident and the resident fell as a result. An interview with the PSW confirmed that they did not ensure that the resident was in a safe position when they turned around to get an item. There was actual harm to the resident, as they sustained an injury, and was determined that it was related to the fall they sustained during the care from the PSW.

Sources: Resident #001's progress notes and chart; home's investigation notes; interviews with a PSW and other staff. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002's plan of care provided clear directions to the staff.

A CIS report was submitted by the home related to resident #002, who sustained a fall and was diagnosed with an injury. A record review of the resident's progress notes indicated that the PT provided a fall prevention intervention for the resident after their fall. The resident's care plan did not indicate that they used that fall prevention intervention. Observations with the resident did not indicate that they used this fall prevention intervention. Interviews with a PSW and an RPN indicated that the resident used this fall prevention intervention while interviews with the OT and another PSW indicated that the resident did not. There was minimal risk to the resident as staff were not clear with whether the resident used this fall prevention intervention.

Sources: Resident #002's progress notes and care plan; Observations with resident #002; Interviews with the PT, PSW's, an RPN, the OT and other staff. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that the registered staff assigned to a resident were made aware of their responsive behaviours.

A review of the progress notes from the resident indicated they had prior incidents of demonstrating responsive behaviours towards co-residents. An RPN and a RN who were assigned to the resident, were interviewed and they were unable to recall details on the responsive behaviours that the resident had or any interventions for them. The NM stated they would have expected this resident's care plan to be reviewed in detail by the registered staff assigned to this resident. There was potential risk of harm to co-residents, as this resident had prior responsive behavioural incidents with co-residents and the registered staff assigned to this resident were not aware of this information, possibly resulting in them not knowing what to do with this resident.

Sources: A resident's progress notes; Interviews with the RN, an RPN, a NM and other staff. [s. 55. (b)]

Issued on this 29th day of October, 2020

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

Original report signed by the inspector.