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

Central East Service Area Office
33 King Street West, 4th Floor
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 10, 2022	2022_882760_0001	019700-21, 021091-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street 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

JACK SHI (760), ELLA LEVINSKAYA (734225)

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 4, 5, 6, 2022.

The following intakes were completed in this critical incident inspection:

A log was related to an incident of resident to resident abuse;
A log was related to an outbreak in the home.

Inspector # 735818 was present during this inspection.

During the course of the inspection, the inspector(s) spoke with a Physician, the Infection Prevention and Control Practitioner, housekeepers, the Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Managers (NM), the Administrator, the Assistant Administrator, and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and essential caregivers (ECGs) followed the home's infection prevention and control (IPAC) practices.

The entire home went into an outbreak due to multiple staff members testing positive for the virus. In addition, at the time of this inspection, there were a number of residents who had tested positive for the virus as well.

According to the Nurse Manager (NM), all staff and ECGs must follow contact/droplet precautions when inside resident rooms and interacting with residents and all staff and ECGs were to wear N95 masks when they went into the resident's rooms to provide care.

Observations were conducted during the inspection and the following concerns were noted:

- A PSW was seen exiting a resident room and was observed without doffing any PPE (Personal Protective Equipment) or had worn a gown when they came out of the room. The PSW stated they did not need to wear a gown or put on additional PPE because they did not touch the resident. The NM stated all staff need to don on appropriate PPE including a gown when entering a resident's room.
- A housekeeper was seen coming out of a resident room and did not wear a gown when they had exited their room.
- A PSW was observed feeding a resident inside their room and did not wear gloves while they were feeding the resident. The PSW stated they did not need to wear gloves because feeding the resident was not considered direct care. The NM stated this was incorrect and the PSW should have been wearing gloves when they were feeding the resident.
- A PSW was seen inside a resident room without their gown or gloves worn while they were in contact with the resident. The PSW was also observed wearing their N95 mask below their nose. The NM stated that the N95 mask should be covering the nose and if it does not, the staff should use another mask that fits their face.
- An RPN was seen inside a resident room without their gown worn. The RPN stated they should have worn the appropriate PPE when going inside the resident rooms.
- A private caregiver inside a resident room had their N95 mask lowered to their chin while they were wearing a gown and face shield. The private caregiver stated they had just finished a snack inside the resident's room and stated they do not leave the resident's room to take their breaks. The NM stated that the private caregivers should not be eating or taking breaks inside resident rooms and there are designated places in the home that they can take their breaks and eat.
- A PSW had went into a resident room with their surgical mask and face shield worn but

did not don or doff any additional PPE. A PSW nearby had told the PSW that they needed to wear their gown before proceeding into the resident's room. Furthermore, the inspector asked about their use of a surgical mask and the PSW stated they forgot to wear their N95 mask and should have done so.
- A PSW was seen inside a resident room without their gown or gloves worn. The PSW was within proximity of the resident. The PSW acknowledged they should have worn the appropriate PPE when they had entered the resident's room.
- A visitor inside a resident room was seen going to the door of the resident's room asking for assistance from staff. The visitor had their N95 mask worn below their nose and did not have a face shield worn. The NM stated the visitor should be ringing a call bell for assistance if they required help from staff and should not have removed their PPE in order to call for assistance.

The observations demonstrated that there were inconsistent IPAC practices performed by the essential caregivers and staff of the home. There was actual risk of harm to residents associated with these observations as the home was in a facility outbreak with a number of residents and staff testing positive for the virus. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the NM and other staff; Observations made throughout the home during the inspection. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 :

1. The licensee failed to ensure that resident #002 was protected from physical abuse by resident #001.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident”.

A Critical Incident Systems (CIS) report was submitted to the Director related to an incident between resident #001 and #002. According to the progress notes, an interaction had occurred between the two residents and as a result, staff had witnessed resident #002 sustain physical injuries from the actions of resident #001. Resident #002 also recalled to staff days after the incident of being afraid of resident #001. An RPN confirmed the events of what had occurred. The Nurse Manager confirmed that based on the events that had occurred, resident #002 was physically abused by resident #001. The failure of protecting resident #002 from resident #001 resulted in resident #002 sustaining emotional and physical trauma from resident #001.

Sources: Review of resident #001 and 002’s progress notes; Home’s investigation notes; Interviews with an RPN, the Nurse Manager and other staff. [s. 19. (1)]

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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to reduce the risk of altercations and potentially harmful interactions related to resident #001's responsive behaviours.

A CIS report was submitted to the Director related to an incident between resident #001 and #002. According to the CIS report, the two residents had an interaction, which had resulted in a physical injury to resident #002. A review of resident #001’s progress notes indicated that prior to this incident, they had displayed responsive behaviours. Resident #001’s care plan did not identify these responsive behaviours or any interventions prior to the incident with resident #002. The BSO RPN stated they had not received any referrals from the front-line staff in the home related to resident #001, prior to the incident with resident #002. The BSO RPN stated that staff should have sent a referral to them and have updated the resident’s plan of care with information on their responsive behaviours including possible triggers and possible interventions to manage their responsive behaviours. Failure to update the resident’s plan of care related to their responsive behaviours may have resulted in a lack of interventions developed to reduce the risk of altercations and harmful interactions with co-residents.

Sources: Information from the CIS Report; Review of resident #001’s progress notes and plan of care; Interviews with the BSO RPN and other staff. [s. 54. (a)]

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

Issued on this 12th day of January, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JACK SHI (760), ELLA LEVINSKAYA (734225)
Inspection No. / No de l'inspection :	2022_882760_0001
Log No. / No de registre :	019700-21, 021091-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 10, 2022
Licensee / Titulaire de permis :	City of Toronto Seniors Services and Long-Term Care (Union Station), c/o 55 John Street, Toronto, ON, M5V-3C6
LTC Home / Foyer de SLD :	Bendale Acres 2920 Lawrence Avenue East, Scarborough, ON, M1P-2T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gina Filice

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. All staff and essential caregivers must adhere to the home's IPAC program.

2. Ensure daily audits are being completed related to the home's IPAC program.

3. Put interventions in place and on the spot education to correct improper practices identified related to the home's IPAC program.

Grounds / Motifs :

1. The licensee failed to ensure that staff and essential caregivers (ECGs) followed the home's infection prevention and control (IPAC) practices.

The entire home went into an outbreak due to multiple staff members testing positive for the virus. In addition, at the time of this inspection, there were a number of residents who had tested positive for the virus as well.

According to the Nurse Manager (NM), all staff and ECGs must follow contact/droplet precautions when inside resident rooms and interacting with residents and all staff and ECGs were to wear N95 masks when they went into the resident's rooms to provide care.

Observations were conducted during the inspection and the following concerns were noted:

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any PPE (Personal Protective Equipment) or had worn a gown when they came out of the room. The PSW stated they did not need to wear a gown or put on additional PPE because they did not touch the resident. The NM stated all staff need to don on appropriate PPE including a gown when entering a resident's room.
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Sources: Interviews with the NM and other staff; Observations made throughout the home during the inspection.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because staff and essential caregivers of the home continued to be non-compliant with the proper IPAC measures, which may possibly lead to the spread of infectious diseases. The home was also in an outbreak with multiple residents and staff testing positive for the virus.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: In the last 36 months, the licensee was found to be non compliant with s. 229 (4) of O. Reg 79/10, and one WN and one CO was issued to the home. (760)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

Service Area Office /
Bureau régional de services : Central East Service Area Office