Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 25, 2023	
Original Report Issue Date: May 11, 2023	
Inspection Number: 2023-1531-0001 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Bendale Acres, Scarborough	
Amended By Wing-Yee Sun (708239)	**Inspector who Amended Digital Signature** Wing Yee Sun 2023.05.25 16:11:10 -04'00'

AMENDED INSPECTION SUMMARY

The licensee inspection report has been revised to reflect an extension to the Compliance Due Date for Compliance Order #001 from June 20, 2023 to July 15, 2023, as requested from the home. The inspection #2023-1531-001 was completed on April 3-6, 11-14, 17-21, 24-26, 2023.

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Lead Inspector Wing-Yee Sun (708239)	**Additional Inspector(s)** Ryan Randhawa (741073) Susan Semeredy (501) Michael Chan (000708) Shuang (Cindy) Ma (000711) was also present during this inspection.
Amended By Wing-Yee Sun (708239)	**Inspector who Amended Digital Signature** Wing Yee Sun 2023.05.25 16:11:45 -04'00'

AMENDED INSPECTION SUMMARY

The licensee inspection report has been revised to reflect an extension to the Compliance Due Date for Compliance Order #001 from June 20, 2023 to July 15, 2023, as requested from the home. The inspection #2023-1531-001 was completed on April 3-6, 11-14, 17-21, 24-26, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3-6, 11-14, 17-21, 24-26, 2023

The following intake(s) were inspected in this Critical Incident System (CIS) inspection:

- Intake: #00007210 - related to falls prevention and management.
- Intake: #00002678 - related to injury of unknown cause.

- Intake: #00006070, Intake: #00008678, Intake: #00016879, Intake: #00019980, Intake: #00022683, Intake: #00022920, Intake: #00022931, and Intake: #00084154 - related to alleged/suspected neglect/abuse.

The following intake(s) were inspected in this Complaints inspection:

- Intake: #00005105, Intake: #00020742, and Intake: #00022007- related to alleged abuse/neglect.

The following intakes were completed in the CIS inspection:

- Intake: #00002361, Intake: #00003630, Intake: #00004876, Intake: #00008510, Intake: #00006079, Intake: #00006662, Intake: #00021122, and Intake: #00021476 - related to falls prevention and management.
- Intake: #00004123, and Intake: #00007772 - related to injury of unknown cause.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

The home's "Mechanical Lifting Device" policy directed staff to refer to the resident's care plan to determine the appropriate device used for transfers and any resident specific instructions.

A resident sustained an injury and required a transfer to the hospital and medical interventions. Prior to the injury, a type of transfer assistance was provided to the resident. Staff were to ensure that a specific intervention was in place prior to the transfer.

A Nurse Manager (NM) and two Personal Support Workers (PSWs) acknowledged that the specific intervention was not in place when the resident sustained the injury during transfer. A Registered Nurse (RN) acknowledged that the specific intervention was meant to protect the resident from injury when they were receiving transfer assistance.

The NM acknowledged that this specific intervention was initiated in the resident's care plan prior to the injury and should have been in place prior to transferring the resident. They acknowledged that staff failed to ensure the resident was safe before, during and after assisting the resident with transferring.

Failure to ensure the resident was assisted using safe transferring resulted in the resident sustaining an injury.

Sources: The resident's clinical records, Critical Incident (CI) Report, home's investigation notes, the home's policy titled "Mechanical Lifting Device, NU-0606-00" – published 01-06-2021, interviews with a PSW, a NM and other staff.

[708239]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that, for two residents who demonstrated responsive behaviours, strategies were implemented to respond to these behaviours.

Summary and Rationale

(i) A resident had an interaction with a PSW stemming from the resident's responsive behaviours and as a result of the interaction, the resident sustained an injury.

The resident's care plan at the time of the incident included the strategies to manage the resident's behaviours. A NM acknowledged that the PSW failed to follow the plan of care for behaviour strategies to manage resident's behaviour as outlined in the resident's care plan.

There was actual harm to the resident when their behaviour strategies that were developed in their plan of care were not implemented by the PSW as the resident sustained an injury.

Sources: The resident's care plan, home's investigation summary, and interview with a NM.

[741073]

Summary and Rationale

(ii) A second resident had a history of responsive behaviours towards staff. A specific intervention was recommended for staff to manage these behaviours. A PSW reported to the Registered Practical Nurse (RPN) that prior to interacting with the resident, the resident was displaying responsive behaviours. The PSW reported that when they responded to the resident's behaviour, it resulted in the resident receiving a negative outcome during the interaction with the PSW.

The PSW acknowledged that the intervention was not in place for the resident, and was not aware of the intervention for the resident at the time of the incident.

A Behavioural Supports Ontario (BSO) Lead acknowledged that a specific intervention was recommended when staff provided care to the resident and should have been in place at the time of the incident.

Failure to provide the resident with the specific intervention at the time of the incident increased the risk that the resident's behaviours were not appropriately addressed by the staff.

Sources: The resident's care plan and progress notes, interviews with a PSW and BSO Lead.

[708239]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure that a resident's right to care and services consistent with their needs was fully respected and promoted.

Rationale and Summary

A resident told a Social Worker (SW) that they were upset with how two PSWs were treating them. The resident required assistance with their activities of daily living (ADL). The resident told the SW that on a specific morning, they asked a PSW to assist them for an ADL. The PSW responded that the resident had the strength to complete the activity themselves. As well, on a different day, the resident asked another PSW to assist them for the same ADL. Because it was time for the PSW to go home, they were irritated and stated they would help them with their ADL and would have a PSW from the oncoming shift, assist with finishing their ADL. The resident was upset with these interactions and the tone of voice used by these PSWs. A NM confirmed the resident's right to be provided care and services was not fully respected and promoted.

Failing to provide assistance with an ADL by two PSWs made the resident feel reluctant to ask for help and put resident at risk for possible adverse outcomes.

Sources: The resident's progress notes and care plan, home's investigation notes, interviews with the resident, a SW and a NM.

[501]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary

(i) A complaint was forwarded to the Ministry of Long-Term Care (MLTC) regarding concerns with the resident having pain due to a medical condition.

The Physiotherapist (PT) received communication regarding the concerns and addressed them with interventions after an assessment was completed.

These interventions were not updated in the resident's care plan until later, after concerns arose regarding the resident's condition.

A NM acknowledged the nurse was expected to update the care plan with the non-pharmacological interventions for pain management, made by the PT.

Another NM acknowledged the resident's care plan should have been updated sooner after the PT assessed the resident.

Failure to implement recommendations for treating the resident's medical condition increased the risk of the resident not being treated when the care plan interventions were not based on their assessed needs.

Sources: The resident's clinical records, CI Report, interviews with two NMs.

[708239]

Rationale and Summary

(ii) The home's "Skin Care and Wound Prevention and Management" policy directed the care team to ensure the resident's care plan was current and accurate based on the resident's individualize treatment plan.

A resident was assessed on a monthly basis by an external consultant for a skin impairment. Based on a consultation report, the resident was recommended to receive a specific treatment for the skin impairment. A month later, the consultant recommended for the resident to receive more frequent treatment to the skin impairment. This increased frequency of treatment continued to be a recommendation for the resident. The increase to the treatment frequency was not changed until much later for the resident.

A NM acknowledged the increase to the treatment frequency change to the skin impairment was not

carried out as recommended. The resident was receiving the previously recommended order for much longer than when it was originally recommended to change. The NM acknowledged the order was expected to have been carried out by the nurse on the unit from when the recommendations were received by the home. They acknowledged the resident's skin impairment remained stagnant for months.

Failure to review and revise the resident's plan of care when the care needs changed increased the risk of the resident's skin impairment deteriorating and delayed healing for the resident.

Sources: The resident's clinical records, Wound Care Consultation Reports, the home's policy "Skin Care and Wound Prevention and Management, RC-0518-02" – published 15-09-2022, and interview with a NM.

[708239]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment, so that their assessments were integrated, consistent and complemented each other.

Rationale and Summary

A resident developed injuries and required further treatment and interventions. The registered staff did not collaborate with each other on assessing this injury. The resident's family became concerned about the worsening condition of the injury and an investigation was initiated. A NM acknowledged that if the worsened injury was brought to their attention immediately, an investigation would have started sooner.

Staff failing to collaborate with management put the resident at risk for further injury as an investigation into what took place was delayed.

Sources: The resident's progress notes, home's investigation notes, interviews with a NM and other staff.

[501]

WRITTEN NOTIFICATION: Complaints Procedure — Licensee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director.

Rationale and Summary

The Substitute Decision Maker (SDM) of a resident sent an email regarding the care of the resident, specifically related to an injury and requested an investigation into what happened.

The home's Managing and Reporting Complaints policy states to immediately report to the Ministry's Director any written complaint that it receives concerning the care of a resident.

This complaint was not forwarded to the Director. A NM acknowledged that the home should have immediately forwarded the SDM's complaint email regarding the care of the resident to the MLTC.

Sources: CIS Report, the home's policy "Managing and Reporting Complaints, AD-0515-00" – published 01-07-2022, and interview with a NM.

[741073]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident exhibiting altered skin integrity was assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

The home's "Skin Care and Wound Prevention and Management" policy directed the registered staff to reassess areas of altered skin integrity at a minimum weekly basis.

The resident was exhibiting altered skin integrity and the registered nurse had initiated the weekly wound assessment on the same day it was discovered. The resident was seen by a nurse and identified there was a skin impairment.

Based on a record review, there were a number of weekly wound assessments missing for the resident.

A NM acknowledged that the weekly wound assessments for the resident's skin impairment were not completed during two specific weeks. They acknowledged the registered staff did not complete the weekly wound assessments according to the home's policy. They acknowledged the risk to the resident was an inability to determine if the skin impairments were improving or not by not completing the weekly wound assessments.

Failure to complete weekly reassessment of the skin impairment may have delayed treatment and healing.

Sources: The resident's Weekly Wound Assessments and progress notes, the home's policy "Skin Care and Wound Prevention and Management, RC-0518-02" – published on 15-09-2022, and interview with a NM.

[708239]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

The licensee has failed to ensure that a resident who was dependent on staff for repositioning was repositioned every two hours.

Rationale and Summary

For residents who were dependent on staff for repositioning, the home's "Skin Care and Wound Prevention and Management" policy directed staff to follow the resident's plan of care for repositioning and turning schedule. Residents should be repositioned every two hours to maintain their skin integrity.

The resident required assistance with repositioning and bed mobility. The resident had developed skin impairments. The intervention to reposition the resident every two hours was initiated in the care plan and staff started documenting the provision of this intervention on Point of Care (POC) much later.

Two PSWs acknowledged they did not start repositioning the resident every two hours until the task appeared on the resident's POC documentation. Prior to this, they reported they would reposition the resident at a lower frequency.

A NM acknowledged the repositioning every two hours was part of the standard of care for anyone with specific skin impairments. They acknowledged the repositioning every two hours should have been happening when the resident's skin impairments first developed and had concerns that staff were not completing repositioning every two hours as the resident's skin impairments were not improving.

Failure to reposition the resident at a minimum of every two hours increased the resident's risk of delayed healing to their skin impairments.

Sources: The resident's clinical records, the home's policy "Skin Care and Wound Prevention and Management, RC-0518-02" – published on 15-09-2022, interviews with two PSWs, and a NM.

[708239]

WRITTEN NOTIFICATION: Police Notification

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, or suspected incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offense.

Rationale and Summary

The home's "Zero Tolerance of Abuse and Neglect" policy directed staff to immediately notify and report all incidents of alleged abuse of a resident to the police known.

A resident's family had noted an injury to the resident and an allegation of staff to resident physical

abuse was brought to the home's attention.

A NM acknowledged that the police were not informed about the allegation of abuse until much later, when the family requested information related to the police investigation. They reported it was an oversight for not reporting the incident on the same day.

The Administrator acknowledged the family had made an allegation of abuse on the day the injury was discovered and expected the RNIC to have called the police on the same day.

Failure to notify police immediately about the allegation of abuse could have delayed timely follow-up into the incident by authorities.

Sources: The resident's progress notes, CI Report, the home's policy "Zero Tolerance of Abuse and Neglect, RC-0305-00" – published 01-06-2021, interviews with a NM and the Administrator.

[708239]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

(a) Provide education to four specific PSWs on the Long-Term Care Home's policies related to prevention of abuse and neglect, roles and responsibilities of PSWs. A record must be kept of the education provided, date of completion, and who provided the education.

(b) Provide education to a PSW on the Long-Term Care Home's policies related to responsive behavioural management and responsive behaviour interventions for a resident. A record must be kept of the education provided, date of completion, and who provided the education.

(c) Perform audits of the provision of care to a resident, related to tasks and interventions for personal care and hygiene as set out in the resident's plan of care. Audits should be performed at minimum twice a week for each shift, days, evening, and nights, for three weeks. Maintain a record of the audits, including the date, who conducted the audit, name of the staff being audited, results of each audit and actions taken in response to the audit findings.

Grounds
Non-compliance with: FLTCA, 2021, s. 24 (1)

(i) The licensee has failed to ensure that a resident was protected from physical abuse by a PSW.

Section 2 of Ontario Regulation (O. Reg.) 246/22, defines “physical abuse” as the use of physical force by anyone other than a resident that causes physical injury or pain.

Summary and Rationale

A resident was demonstrating responsive behaviours when a PSW attempted to intervene and used inappropriate physical force and as a result, the resident sustaining an injury.

A NM acknowledged that the PSW used physical force when they attempted to intervene after the resident demonstrated responsive behaviours which resulted in the resident sustaining an injury. The NM confirmed that the incident met the definition of physical abuse, and that the resident was not protected from abuse by the PSW.

There was actual harm to the resident as they sustained an injury after the PSW inappropriately intervened in this incident.

Sources: The home’s investigation summary, the home’s policy "Zero Tolerance of Abuse and Neglect, RC-0305-00" - published 01-01-2021, and interview with a NM.

[741073]

(ii) The licensee has failed to ensure that a resident was protected from physical abuse by a PSW.

O. Reg. 246/22, defines “physical abuse” as the use of physical force by anyone other than a resident that causes physical injury or pain.

Summary and Rationale

A resident had refused personal care, however a PSW applied inappropriate force to have the resident comply with personal care.

A NM acknowledged that the PSW used physical force that caused an injury after the PSW

inappropriately responded to the resident's refusal of personal care. The NM confirmed that the incident met the definition of physical abuse, and that the resident was not protected from abuse by the PSW.

There was actual harm to the resident as they sustained an injury after the PSW applied inappropriate physical force on the resident.

Sources: The resident's progress notes, the home's policy "Zero Tolerance of Abuse and Neglect Policy, RC-0305-00" - published 01-01-2021, interviews with the resident and a NM.

[741073]

(iii) The licensee has failed to ensure that a resident was protected from neglect.

Section 7 of the O. Reg. 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A resident did not receive personal care after it was requested due to a miscommunication between staff members, along with a staff member refusing to provide personal care to the resident. The family provided personal care to the resident without the assistance from the staff.

It was determined that the resident did not receive care on a specific date for a number of hours as a result of miscommunication amongst the staff. This lack of clarity and refusal of one of the PSWs to provide care, resulted in the resident being neglected and put at risk for further harm. A NM and other staff confirmed that the resident was neglected in this incident.

Sources: Home's investigation notes, the resident's progress notes, POC Documentation Survey Report v2, and care plan, interviews with a NM and other staff.

[000708]

This order must be complied with by July 15, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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