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: August 4, 2023
Original Report Issue Date: July 28, 2023
Inspection Number: 2023-1531-0002 (A1)
Inspection Type: Follow up Critical Incident System
Licensee: City of Toronto
Long Term Care Home and City: Bendale Acres,Scarborough

Amended By	**Inspector who Amended Digital Signature**
Michael Chan (000708)	Michael K Chan Digitally signed by Michael K Chan Date: 2023.08.04 11:13:56 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to reflect the following previously issued Compliance Order was found to be in compliance: Order #001 from Inspection #2023-1531-0001 related to FLTCA, 2021, s. 24 inspected by Michael Chan (000708). The inspection 2023-1531-0002 was completed on July 24, 2023.

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Inspection Type: Follow up Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Bendale Acres, Scarborough	
Lead Inspector Michael Chan (000708)	**Additional Inspector(s)** Susan Semeredy (501) Henry Chong (740836)
Amended By Michael Chan (000708)	**Inspector who Amended Digital Signature** Michael K Chan Digitally signed by Michael K Chan Date: 2023.08.04 11:15:12 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to reflect the following previously issued Compliance Order was found to be in compliance: Order #001 from Inspection #2023-1531-0001 related to FLTCA, 2021, s. 24 inspected by Michael Chan (000708). The inspection 2023-1531-0002 was completed on July 24, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17-21, 24, 2023.

The following intake(s) were inspected in the Follow-Up Inspection:

- Intake: #00087752 - a follow-ups intake related to a previously issued Compliance Order

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00086175 - M504-000029-23 - Unexpected death of a resident
- Intake: #00087070 - M504-000031-23 - Alleged neglect of resident
- Intake: #00088731 - M504-000035-23 - Injury of unknown cause of a resident
- Intake: #00091907 - M504-000045-23 - Fall of resident resulting in injury

The following intake(s) were completed in the CIS Inspection:

- Intake: #00090252 -M504-000039-23, Intake: #00087564 - M504-000032-23, and Intake: #00087642 -M504-000033-23 - Fall of resident resulting in injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order # from Inspection #2023-1531-0001 related to FLTCA, 2021, s. 24 inspected by Michael Chan (000708)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure that the home was a safe environment for a resident.

Rationale and Summary
The home submitted a report received from a resident's substitute decision maker (SDM) regarding the home's response to an incident where the resident sustained an injury and was transferred to the hospital.

One resident heard a bang and found the other resident in their room and pulled the call bell. Staff responded to the call bell and found resident on the floor. There were no registered staff working on the floor that night, so staff left the resident that was on the floor and went to inform the registered staff on another floor. The registered staff sent the staff back to the resident on the floor and called the in-charge staff who responded. By that time, the resident had moved themselves.

A staff stated they were unsure what number to reach the registered staff at, so they went to find them. They acknowledged they should not have left the resident alone. Staff admitted they did not interrupt a staff member who was on their break even though the staff member was in the vicinity. A staff member admitted the resident was their assigned resident and only became aware of the fall after their break.

Management acknowledged it was unsafe for staff to leave the resident alone after finding them on the floor as further injury could have occurred when the resident moved on their own.

Sources: The home's investigation notes, and interviews with the resident, staff, and management. [501]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (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 when the resident was reassessed after recovering from an injury.

Rationale and Summary
A resident sustained an injury. Prior to the injury, the resident required a specific type of transfer. On a specified date, staff changed the resident's plan of care to require assistance with transfers. Staff assessed the resident indicated they required a specific type of assistance with transfers. Staff admitted they did not take into account the of the assessment when updating the plan of care and no referral were sent for reassessment of the resident. Management confirmed nursing staff should have collaborated with the other disciplines when reassessing a resident's transfer status.

Failure to involve other disciplines in the reassessment of the resident placed the resident at risk for another injury.

Sources: Resident's clinical records, interviews with staff, and management. [501]

WRITTEN NOTIFICATION: Minimizing of Restraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)

The licensee has failed to ensure that the use of a personal assistance service device (PASD) used to assist a resident with a routine activity of living was included in the plan of care.

Rationale and Summary
Staff observed a resident's change in their health condition. Staff adjusted the resident's position, and the resident's health condition changed.

Resident was assessed by staff for using a specific device for locomotion. Staff and management confirmed the use of the device should be included in their plan of care and registered staff were responsible to update the plan of care. No direction was provided in the plan of care for the resident.

Failure to ensure that the written plan of care for the resident provided clear directions to staff increased the risk for inconsistent provision of care to the resident.

Sources: The home’s investigation notes, resident's clinical record, interviews with the home's staff and management. [000708]

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