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

Original Public Report

Report Issue Date: September 12, 2023

Inspection Number: 2023-1531-0003

Inspection Type:
Complaint
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Bendale Acres, Scarborough

Lead Inspector	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2023.09.13 12:30:07 -04'00'

Additional Inspector(s)
Nrupal Patel (000755)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28-31, 2023 and September 5-7, 2023
The inspection occurred offsite on the following date(s): September 1, 2023

The following Critical Incident (CI) intake(s) were inspected:
- Intake: #00092760 related to an injury of unknown cause.
- Intake: #00093601 related to an injury from a fall.

The following Complaint intakes were inspected:
- Intake: #00093001 and #00093566 related to resident care.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the resident had an equipment used in a manner as specified in the care plan.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Director related to a resident fall leading to an injury. A review of the resident's clinical records indicated the resident's care plan required staff to ensure that an equipment was arranged in a certain manner to the resident.

During an observation, the equipment was not placed in accordance to the directions on the resident's care plan. Personal Support Worker (PSW) and Registered Practical Nurse (RPN) confirmed that the equipment was not placed in a manner as per their care plan. Nurse Manager acknowledged the same and stated that the staff must follow the care plan.

Failure to ensure the resident had the equipment placed in the correct manner, put the resident at risk of falls and falls-related injuries.

Sources: Observations, resident's care plan, interview with PSW, RPN and Nurse Manager.

[000755]