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
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Original Public Report

Report Issue Date: November 16, 2023	
Inspection Number: 2023-1531-0004	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Bendale Acres, Scarborough	
Lead Inspector Ann McGregor (000704)	**Inspector Digital Signature** Ann McGregor Digitally signed by Ann McGregor Date: 2023.11.21 16:43:19 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 23-24, 26-27 and November 1-3, 2023.

The following intake was inspected in the complaint inspection:

- Intake: #00098698 related to an allegation of resident-to-resident abuse.

The following intake was inspected in this Critical Incident (CI) Inspection:

- Intake: #00099246/CI#M504-000071-23 - Injury of unknown cause.

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

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee has failed to ensure that staff complied with the home's policy for Behavioural Assessment Tool: Modified Dementia Observation System (BSO-DOS), RC-0517-07, published 15-09-2022.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their actions taken to respond to the needs of residents with responsive behaviours, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Specifically, staff did not comply with the home's policy related to ensuring that BSO-DOS monitoring tool was completed for the resident on several occasions.

Rationale and Summary
A resident's BSO-DOS monitoring tool was not completed consistently which prevented the review of the DOS data and the responses to reduce or minimize the frequency and severity of incidents.

A complaint was submitted to the Director, informing of an alleged abuse on a resident by a co-resident. The co-resident demonstrated responsive behaviour and was being monitored using the BSO-DOS tool.

A review of the health care records identified that the resident displayed new and escalating responsive behavior on several days. A BSO-DOS monitoring tool was initiated and required ongoing monitoring and documentation of the behaviour.

The BSO-DOS document was not completed in a period of times on various shifts.

An interview with a Personal Support Worker (PSW) confirmed that the DOS monitoring tool was not completed during their shift. A Registered Practical Nurse (RPN) confirmed that the tool should have been completed by all staff on each shift.

An interview with the Behavioural Support Ontario (BSO) lead confirmed that the home has failed to complete the DOS monitoring tool as per policy.

The failure to complete the DOS monitoring tool may have impacted the safety and security of another resident.

Sources: Complaint intake; resident's clinical records; home's policy, "Behavioural Assessment Tool: Modified Dementia Observation System (DOS) RC-0517-07 published 15-09-2022" and interview with the PSW and others.
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WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of their Infection Prevention and Control (IPAC) program.

Rationale and Summary
A RPN was observed entering a resident's room and did not participate in the home's IPAC practice prior to entering the resident's room.

The home's IPAC policy was not complied with when the staff entered a resident's room and did not perform hand hygiene.

The staff did not comply with the home's IPAC policy.

IPAC Practitioner confirmed that staff did not follow the Long-Term Care Home's policy in relation to IPAC.

There was a risk of infection transmission when staff did not participate in the home's IPAC practices.

Sources:
Observation; Hand Hygiene policy #IC-0606-01 published June 01, 2021; and interviews with the RPN and other staff.
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