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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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: December 12, 2023	
Inspection Number: 2023-1531-0005	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Bendale Acres, Scarborough	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.12.13 15:30:02 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-8, 2023.

The following intake(s) were completed in this complaint inspection:

- Intake #00101817 and Intake #00100885 were related to Infection Prevention and Control concerns (IPAC).

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake #00098847/M504-000069-23 was related to a fall of a resident with injury.
- Intake #00100181/M504-000073-23 was related to suspected staff to resident abuse.
- Intake: #00100885/M504-000075-23 was related to late reporting of an outbreak.

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (c)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(c) removal and safe disposal of dry and wet garbage; and

The licensee failed to ensure that dry and wet garbage was removed on a specified date.

Rationale and Summary:

On a specified date, the inspector observed a garbage bag full of wet and dry garbage outside in the hallway on a particular floor. The garbage bag was no longer there after the inspector spoke with Housekeeping staff #003.

Housekeeping staff #003 acknowledged they did not throw out the garbage bag because they were providing assistance to maintenance staff. Environmental Consultant #009 stated the process is for housekeeping staff to store the garbage bag inside a particular room unless there is an emergency.

Sources: Observations on a specified date; Interviews with staff.

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Date Remedy Implemented: on a specified date.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care related to an intervention for their skin integrity was provided to a resident.

Rationale and Summary:

A CI was submitted to the Director reporting a suspected neglect related to staff to resident care as a resident was found with identified injuries.

The resident's care plan stated the resident was at risk of developing these injuries and an intervention was developed. On a specified date, a direct care staff failed to document providing this intervention to the resident.

They acknowledged they did not provide the intervention to the resident. The Director of Nursing (DON) stated that the direct care staff are responsible to follow the intervention in the resident's plan of care.

Failure to provide this intervention to the resident placed the resident at risk for further injuries.

Sources: Resident's Plan of Care; Interview with staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary; or

The licensee has failed to ensure that resident #001 was reassessed and the plan of care was reviewed and revised when their care needs changed.

Rationale and Summary:

The resident was provided with recommendation by the Medical Doctor (MD) to wear provide an intervention to the resident every shift. The resident's care plan stated a different schedule of when to provide this intervention.

A direct care staff and registered staff stated the resident was to follow the MD's direction on providing the intervention to the resident. A registered staff acknowledged that there was a discrepancy between the direction from MD and the resident's current care plan which should have been revised.

The DON stated the expectation of the staff is to revise the plan of care for resident as it should be reflective and accurate of the resident's care needs.

Failure to include new interventions related to resident's current care needs put them at potential risk of not receiving their care according to their needs

Sources: Resident's Plan of Care; Interviews with staff.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee failed to ensure that all staff participated in the implementation of the hand hygiene program on a specified date.

Rationale and Summary:

On a specified date, the inspector observed a registered staff provide alcohol-based hand rub (ABHR) to multiple residents as they were walking into the dining room on a particular floor as part of their hand hygiene program. Once the observation was completed, the inspector noted that the ABHR was expired.

The home's policy stated that the building services staff shall ensure that adequate hand hygiene supplies are available in resident home areas including adequate liquid soap/dispensers, paper towels, and ABHR.

A direct care staff stated they assumed there would not be expired ABHRs in the dining room. A direct care staff and a registered staff stated they did not check the expiration of the ABHRs when they provided to the residents. A registered staff acknowledged that they provided an expired ABHR. They further stated that direct care staff are supposed to report expired ABHRs to the registered staff who can communicate to the nursing clerk (who is responsible to provide supplies of ABHRs

to all the units).

Nursing Clerk stated they did not receive any communication from the nursing staff on the specified floor regarding expired ABHRs since June 2023.

IPAC Practitioner and DON stated that expired ABHR is not to be used as part of the resident hand hygiene program.

Failure to ensure staff participation in the implementation of the hand hygiene program may have contributed to multiple residents at risk of infection.

Sources: Observations on a specified date; Hand Hygiene IC-0606-01 (Published 01-06-2021); interviews with staff.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary

On a specified date, a critical incident report was submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent out on August 18, 2023 indicated that for critical incidents reported immediately outside of business hours, to call the Service Ontario After-Hours Line.

Nurse Manager/IPAC lead #020 confirmed that the home submitted a critical incident report but did not call the Service Ontario After-Hours Line.

Sources: Critical Incident Report M504-000075-23; MLTC Reporting Requirements - reference sheet; and interview with NM/IPAC lead #020.

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