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: June 20, 2024	
Original Report Issue Date: May 17, 2024	
Inspection Number: 2024-1531-0003 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Bendale Acres, Scarborough	
Amended By Britney Bartley (732787)	**Inspector who Amended Digital Signature** Britney Bartley Digitally signed by Britney Bartley Date: 2024.06.20 10:35:13 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
To correct the role of an individual stated in non-compliance #003.

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Amended Public Report (A1)

Amended Report Issue Date: June 13, 2024	
Original Report Issue Date: May 17, 2024	
Inspection Number: 2024-1531-0003 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Bendale Acres, Scarborough	
Lead Inspector Britney Bartley (732787)	**Additional Inspector(s)** Goldie Acai (741521)
Amended By Britney Bartley (732787)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
To correct the role of an individual stated in non-compliance #003.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17-19, 22, 23, 25, 26, 2024.
The following intake(s) were inspected in this Critical Incident (CI) report:
· Intake: #00110845 – A complainant regarding a discharge of a resident.
· Intake: #00112555 – A resident sustained an injury of unknown cause.
· Intake: #00112964 – A disease outbreak.
· Intake: #00109523 – Fall of a resident resulting in injury.

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The following intakes were completed in this inspection: Intake: #00110084 was related to a fall with injury.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management
Admission, Absences and Discharge

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Restriction on discharge

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 156
Restriction on discharge
s. 156. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation.

The licensee has failed to ensure that no licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation.

Rationale and Summary

A resident was admitted to the home and discharged the same day.

The resident exhibited responsive behaviours that resulted in an incident.

The Administrator indicated in discussion with other staff, that discharging the resident was their best option as the resident posed a concern to co-residents and staff. In addition, the home did not consider the 30-day bed hold for the resident.

Failure of the home to ensure they did not discharge the resident unless permitted or required to do so by this Regulation resulted in a resident losing their bed and may have negatively impacted their ability and chance of finding appropriate supports, as well as the ability to express their wishes regarding their discharge.

Sources: A resident's clinical records, interviews with a counsellor, the Administrator, and other staff.

[732787]

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (a)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

The licensee has failed to ensure that before discharging a resident under subsection 157 (1), ensure that alternatives to discharge have been considered and, where appropriate and tried.

Rationale and Summary

A resident was admitted to the home and discharged on the same day.
The Administrator indicated they discussed alternative options with the team members at the home. They concluded with discharging the resident because the resident posed a concern to co-residents and staff and was not a candidate for certain units.

In review of a resident's clinical health record there was no documentation demonstrating alternatives were considered or tried before implementing an intervention.

When the home failed to ensure alternative to discharging the resident was considered, the resident's rights were not considered which had a negative impact on the resident.

Sources: A resident's clinical health record, interviews with the Administrator, and other staff.

[732787]

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

The licensee has failed to ensure that before discharging a resident they collaborated with the appropriate placement co-ordinator and other health service organizations, to make alternative arrangements for the accommodation, care and secure environment

required by the resident.

Rationale and Summary

The Administrator indicated before discharging the resident, they did not collaborate with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required for the resident.

In review of a resident's clinical health record there was no documentation demonstrating any collaboration with the appropriate placement co-ordinator and other health services.

When the home did not collaborate with the appropriate placement coordinator to make alternative arrangements for the accommodation, care and secure environment required for a resident, the resident's rights were not considered which had a negative impact on the resident.

Sources: A resident's clinical records, interviews with the Administrator, and other staff.

[732787]

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(c) ensure the resident and the resident's substitute decision-maker, if any, and any

person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

The licensee has failed to ensure that before discharging a resident under subsection 157 (1) that the resident and the resident's substitute decision-maker is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration.

Rationale and Summary

A nurse was instructed by the Assistant Administrator to call the resident's SDM to inform them of the incident and to organize picking up their belongings. The Administrator indicated when the family member arrived, they voiced concerns and requested the resident to be transferred to another unit in the home. The Administrator informed them the home cannot do internal transfers and that they should apply to the appropriate unit.

The Administrator indicted before discharging the resident the home did not give the SDM's an opportunity to participate in the discharge planning and that their wishes were not taken into consideration.

In review of the resident's clinical health record there was no documentation demonstrating any discussion had occurred with the resident's SDM before the discharging the resident.

Failure to ensure a resident's SDM was able to participate with the discharge planning, may have negatively impacted their ability of finding appropriate supports, as well as the ability to express their wishes regarding their discharge.

Sources: A resident's clinical records, interviews with a nurse, the Assistant Administrator, the Administrator, and other staff.

[732787]

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The licensee failed to ensure that before discharging a resident, the resident and the resident's substitute decision-maker was provided a written notice to the setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Rationale and Summary:

A letter was couriered to the resident's SDM after the resident was discharged. By not providing a written notice to the resident and the resident's SDM of the discharge before the discharge, may have negatively impacted their ability and chance of finding appropriate supports, as well as the ability to express their wishes.

Sources: A resident's clinical records, a letter, interviews with the Administrator, and other staff.

[732787]