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
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# Original Public Report

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| **Report Issue Date:** October 30, 2024 |
| **Inspection Number:** 2024-1531-0005 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** City of Toronto |
| **Long Term Care Home and City:** Bendale Acres, Scarborough |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 8-11, 2024

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake: #00120123 - CI #M504-000036-24 and intake: #00126222 - CI #M504-000049-24 were related to Prevention of Abuse and Neglect
- Intake: #00127940 - CI #M504-000054-24 was related to Infection Prevention and Control Program
- Intake: #00128117 - CI #M504-000056-24 was related to Fall Prevention and Management Program

The following intakes were completed in this CI inspection:

- Intake: #00128044 - CI #M504-000055-24 and intake: #00126736 - CI #M504-000051-24 were related to Fall Prevention and Management Program

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

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: FLTCA, 2021, s. 6 (7)**
Plan of care
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 a fall prevention equipment that was set out in a resident's plan of care, was provided to the resident.

**Rationale and Summary**
A resident's plan of care indicated that they were at risk of fall, and required to have a fall prevention equipment in place. During an observation the fall prevention equipment was not in place.

A Nurse Manager (NM) acknowledged the fall prevention equipment was not in place. They requested the registered nursing staff to provide it to the resident. During another observation the fall prevention equipment was in place and was functional.

Failure to provide fall prevention equipment to the resident as set out in their care plan may put the resident at risk of fall.

**Sources:** The resident's clinical records, two observations of the resident, interview with a NM.

## WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 11 (1) (b)**
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

The licensee has failed to comply with nursing and personal support services program for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to have a written description of the nursing and personal support services that includes its goals, objectives, procedures and protocols, and must be complied with.

Specifically, a Personal Support Worker (PSW) did not comply with the home's "Nursing and Personal Care Records" policy related to accurate documentation of care.

**Rationale and Summary**
A resident's clinical records indicated that a PSW provided care to the resident at a certain time. However, the home's investigation notes indicated that the PSW did not provide any care to the resident at that time or at any time prior during their shift.

The home's "Nursing and Personal Care Records" policy indicated that "It is the standard in the Long-Term Care Homes & Services Division that nursing and personal care staff document care and services delivered each shift. The Nursing and Personal Care Record provides the documented evidence upon which resident assessments are completed and reflects daily nursing and personal care delivered to residents."

The PSW confirmed that they did not enter the resident's room to provide any care for them at that time or any time prior during their shift, however they documented in the clinical electronic system that they provided care to the resident. They confirmed their documentation did not accurately reflect the care provided to the resident. A NM indicated that the documentation of the care to the resident should occur after the provision of care to the resident.

Failure to follow home's "Nursing and Personal Care Records" policy caused confusion in determining whether resident's care was delivered as outlined in their plan of care.

**Sources:** The resident's clinical records, home's investigation notes, home's "Nursing and Personal Care Records Policy", interviews with a PSW and a NM.

## WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (4) (b)**
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that a PSW collaborated in the implementation of a resident's plan of care.

**Rationale and Summary**
A resident alleged that they were left for a certain period of time and did not receive any assistance from staff for care. According to resident's care plan, the resident required staff assistance for care.

A PSW stated they were unavailable during that time and noted this to another PSW and the resident. According to the home's audit report, the resident had requested for assistance multiple times during the period they were left in the designated area and no staff responded. The PSW acknowledged they could have called for another staff to assist in this resident's care needs.

A NM acknowledged that the PSW failed to collaborate with the nursing team when it came to meeting this resident's care needs.

Failure to collaborate on this resident's care needs lead to the resident not receiving timely care from the staff.

**Sources:** The resident's clinical records; Home's investigation notes and audit records; Interviews with two PSWs, a RPN and a NM.

## WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (4) (a)**
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and the Occupational Therapist (OT) involved in the different aspects of care of a resident collaborated with each other, in the assessment of the resident's fall prevention equipment so that their assessments were integrated and were consistent with and complemented each other.

**Rationale and Summary**
A resident sustained a fall which resulted in injury. The OT has assessed the resident and recommended to the care team to monitor the resident for a certain period of time and send a referral to the OT if the resident was not compliant with the fall prevention interventions in place. The resident was continuously refusing to use the fall intervention equipment, however no referral was sent to the OT related to the resident's non-compliance with the fall interventions.

Two RPNs confirmed that they did not send a referral to the OT to reassess the resident's fall prevention equipment. The OT indicated that the resident's fall prevention interventions should have been reassessed by the OT when they were not effective.

Failure to collaborate between the staff and the OT, the resident's fall prevention equipment were not reassessed when they were found to be ineffective and placed them at risk for further falls and injuries.

**Sources:** The resident 's clinical records, interview with two RPNs, the OT and a NM.

## WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (5)**
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

**Rationale and Summary**
A CI report was submitted to the Director when a resident's family member sent a written complaint reporting an allegation of abuse. It was indicated that the family member had concerns with resident's injury that they identified during their visit with the resident. The resident's clinical records indicated that a RPN assessed the resident earlier on a same day and identified the resident's injury.

Two RPNs confirmed that they did not contact the resident's SDM to inform them about the resident's injury.

By failing to ensure that the resident's SDM was made aware of the resident's injury, they were not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

**Sources:** The resident's clinical records, CI report, interviews with two RPNs and a NM.

## WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 25 (1)**
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure a RPN complied with the home's written policy related to zero tolerance of abuse and neglect of residents.

**Rationale and Summary**
A resident had spoken with a RPN related to an allegation that they were left unattended in designated area for a certain period of time. The resident had brought forward their allegations to the Administrator, which then initiated the home's investigation into this allegation.

According to the home's policy titled, "Zero Tolerance of Abuse and Neglect", the registered staff were to report any suspected allegations of resident neglect to either the Registered Nurse In Charge (RNIC) or NM.

A NM stated the home's policy and process would be to have the RPN report these allegations immediately to their supervisor, either the RNIC or the nurse manager.

Failure to ensure that an alleged incident of staff to resident neglect was reported immediately may have delayed the opportunity to gather information related to the alleged incident and take appropriate action to prevent further harm to the resident.

**Sources:** The Resident's clinical records; Home's policy titled, "Zero Tolerance of Abuse and Neglect"; Interviews with a RPN, a RNIC, the Administrator and a NM.

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)**
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident 's symptoms were recorded on two certain shifts.

**Rationale and Summary**
A Resident was experiencing symptoms from the onset of the shift and later diagnosed with a respiratory infection. A review of the progress notes and assessments section on clinical electronic system for two shifts indicated there was no documentation to support the monitoring of the resident's symptoms during that shift.

An Infection Prevention and Control (IPAC) Manager stated that the staff should document in the clinical electronic system and use a specialized respiratory assessment tool when monitoring the resident's infectious symptoms. The IPAC Manager confirmed that this process was not followed through for those two shifts.

Failure to document a resident's symptoms may lead to a delay in required treatments.

**Sources:** Review of a resident's clinical records; Home's line list of residents

affected by the outbreak; Interview with the IPAC Manager.

## COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

1. Conduct random audits, on different days, of a RPN while they are providing medications to residents to ensure they are performing hand hygiene in accordance to the four moments of hand hygiene. The audits should include the name of the person conducting the audit, when it was done, whether the four moments of hand hygiene were performed. The audit shall also include details of any follow up actions taken if the RPN did not follow the four moments of hand hygiene.

2. Provide education to a PSW on the steps of doffing personal protective equipment (PPE).
3. Conduct random audits on the PSW related to the steps of doffing PPE. The audits should include the name of the person conducting the audit, when it was done and whether the doffing was done correctly. The audit shall also include details of any follow up actions taken if the PSW did not follow the proper steps of doffing PPE.

4. Keep a written record of the education and audits for steps one, two and three of the order. For the education, ensure the following is included: the person providing the education, when it was done and the education content provided.

**Grounds**

i) The licensee has failed to ensure that a RPN performed hand hygiene as required by routine practices.

The RPN failed to ensure that they performed hand hygiene in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the RPN did not ensure that the four moments of hand hygiene was followed through as indicated in Additional Requirement 9.1 under the IPAC Standard.

**Rationale and Summary**
On an outbreak home area, a RPN was observed giving medications to a resident and did not complete hand hygiene after the resident interaction. The RPN then went to another resident to give them their medications. The RPN acknowledged they should be performing hand hygiene in between giving residents their medications.

Failure to ensure that hand hygiene was performed in accordance to four moments may lead to further spread of infectious diseases.

**Sources:** An observation of a RPN and interview with them.

ii) The licensee has failed to ensure that a PSW appropriately doffed their PPE.

The PSW failed to ensure that they doffed their PPE accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the PSW did not ensure that they had cleaned their face shield after coming out of a contact/droplet isolation room, which was part of

the home's procedures of proper removal of PPE as indicated in Additional Requirement 9.1 under the IPAC Standard.

**Rationale and Summary**
A PSW was observed exiting out of a resident's room who was on contact/droplet isolation for an infectious disease. The PSW did not clean their face shield when they had exited the resident's room. The PSW acknowledged that they should have cleaned their face shield upon exiting this resident's room.

Failure to ensure that proper PPE doffing procedures are followed may result in further spread of infectious diseases.

**Sources:** An observation of a PSW and interview with them.

**This order must be complied with by** November 29, 2024.

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**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

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.