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: August 20, 2024
Inspection Number: 2024-1531-0004
Inspection Type: Complaint 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): July 25, 26, 30, 31, 2024 and August 1, 2, 6-9, 12, 2024

The following Critical Incidents (CIs) were inspected in this inspection:

- Intakes: #00114584, #00118878, #00119739 - related to a resident's fall that resulted in injury.
- Intake: #00117665 – related to alleged abuse of a resident.
- Intakes: #00117723, #00120075 – related to unknown cause of an injury.
- Intakes: #00118680, #00119283 – related to an infectious disease outbreak.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

The licensee failed to ensure that there was information posted related to visitors not entering the home if they are ill. Specifically, section 11.6 of the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022 stated "the licensee shall provide individuals with information to monitor their health at home for symptoms and inform them that they are not permitted to enter the home if they are feeling ill or would otherwise fail screening".

Rationale and Summary:

(i) The LTCH did not have signage at the entrance informing visitors that they are not permitted to enter the home if they are feeling ill or would otherwise fail screening. IPAC lead confirmed information related to the above was not posted in the home.

Failure to ensure that all individuals entering the home are informed not to enter if

they are symptomatic, increased the risk of the entrance and transmission of infectious agents in the home.

Sources: Observations, Interview with the IPAC Lead.

The licensee has failed to ensure that an additional precaution sign was visibly posted. Specifically, section 9.1 states that the "licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program", and that "at a minimum, Additional Precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place".

Rationale and Summary:

(ii) A resident room was observed to have IPAC supplies, but no additional precaution signage was visible. An additional precaution sign was noted to be posted behind the IPAC supplies.

A RN confirmed that the additional precaution signage was not visible.

Failure to ensure additional precaution signage was visibly posted, placed individuals at risk of entering a resident room without knowing the proper precautions to take, and subsequently, the transmission of infectious agents.

Sources: Observations, interview with a nurse.

The licensee has failed to ensure that staff completed hand hygiene after resident contact. Specifically, section 9.1 states "the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At a minimum, Routine Practices shall include hand hygiene, including, but not limited to,

the four moments of hand hygiene before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact".

Rationale and Summary:

(iii) A PSW was observed exiting a resident room without performing hand hygiene, looking through a cart that carried personal care items, and re-entering the same resident room without performing hand hygiene.

Additionally, a student PSW was observed exiting a resident room without performing hand hygiene and taking gloves from a box on a cart in the hallway.

Both PSW and Student PSW confirmed that they did not comply with routine hand hygiene practices.

IPAC Lead confirmed that both staff were non-compliant with the Home's expectations on hand hygiene.

Failure to complete hand hygiene upon exiting a residents' room risked the transmission of infectious agents.

Sources: Observations, PSW Student and IPAC Lead.