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

Public Report

Report Issue Date: March 4, 2025

Inspection Number: 2025-1531-0002

Inspection Type:
Other
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Bendale Acres, Scarborough

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 18-21, 25-28, March 3-4, 2025, with February 18-21, 25-27, March 3-4 conducted on-site and February 28, 2025 conducted off-site.

The following intake(s) were inspected:
• Intake: #00135488 – [Critical Incident (CI): M504-000075-24] - related to abuse
• Intake: #00136166 – [CI: M504-000001-25] - related to allegation of neglect
• Intake: #00137007 – [CI: M504-000004-25] - related to a disease outbreak
• Intake: #00139201 – related to Emergency Plans
• Intake: #00139378 – [CI: M504-000010-25] – related to abuse

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that resident #001 was protected from physical abuse by resident #002, and resident #002 was protected from physical abuse by resident #001.

Ontario Regulation (O. Reg.) 246/22 s. 2 (1), defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

Residents #001 and #002 were witnessed having a physical altercation. Both residents sustained injury as a result of the altercation.

Sources: Residents' clinical notes; and interviews with a PSW and Nurse Manager.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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 has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were recorded in accordance with any standard or protocol issued by the Director. A resident was placed in additional precautions for one and half weeks for a suspected infectious disease. There was missing documentation to support the monitoring of the resident's signs and symptoms of infection on multiple days.

Sources: Resident's clinical records; interview with the IPAC Lead.

WRITTEN NOTIFICATION: Attestation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to ensure that the emergency planning attestation form was submitted annually to the Director by December 31, 2024. The Administrator confirmed that they did not submit the emergency planning attestation form to the Director by the due date.

Sources: Home's Emergency Planning Attestation Form; and interview with the Administrator.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Educate all PSWs and registered staff who work on a specified resident home area, to review two residents' plan of care, specifically related to the implementation of behaviour management interventions.
2. Document and maintain a record of all education, including the staff names, title, signature of the persons the education was provided to, and the date and time it was provided, and the name of the person who provided the education.
3. Conduct once-daily audits, for a period of two weeks following the service of this order, to ensure behaviour management interventions are implemented for two residents, as specified in the plan of care.
4. Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, staff and residents audited, outcome and actions taken as a result of any deficiencies identified.

Grounds

The licensee has failed to ensure that for two residents who demonstrated responsive behaviours, intervention strategies were implemented to respond to these behaviours.

Rationale and Summary
i) A resident had responsive behaviours, and could be aggressive. Behaviour

interventions to respond to the resident's responsive behaviours included use of a specified equipment on their room door and also a logo posted in hallway walls.

Observations revealed the aforementioned behaviour interventions were not implemented.

A Registered Nurse (RN) and Behavioural Supports Ontario (BSO) Lead acknowledged that behaviour interventions as specified in the resident's plan of care should have been implemented to respond to the resident's responsive behaviours.

There was increased risk of harm to the resident and co-residents when their behaviour interventions were not implemented.

Sources: Observations, resident's clinical notes; interviews with a RN and BSO Lead.

iii) A resident had responsive behaviours and could be aggressive. Behaviour interventions to respond to the resident's responsive behaviours included use of a specified equipment on their room door.

Observation revealed that the specified equipment was not applied on the resident's door.

A Registered Nurse (RN) and Behavioural Supports Ontario (BSO) Lead acknowledged that behaviour interventions as specified in the resident's plan of care should have been implemented to respond to the resident's responsive behaviours.

There was increased risk of harm to the resident and co-residents when their behaviour intervention was not implemented.

Sources: Observations, resident's clinical notes; interviews with a RN and BSO Lead.

This order must be complied with by April 11, 2025

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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:

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.