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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Public Report

Report Issue Date: May 20, 2025

Inspection Number: 2025-1531-0004

Inspection Type:
Critical Incident
Follow up

Licensee: City of Toronto

Long Term Care Home and City: Bendale Acres, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14-16, 20, 2025

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00142529 – [CIS: M504-000017-25] – Injury of unknown cause
- Intake: #00142776 – [CIS: M504-000020-25] - Medication management
- Intake: #00143602 – [CIS: M504-000022-25] – Staff to resident abuse
- Intake: #00144673 – [CIS: M504-000025-25] – Injury of unknown cause

The following follow-up intake(s) were inspected:
- Intake: #00141535 – Responsive behaviours

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1531-0002 related to O. Reg. 246/22, s. 58 (4) (b)

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

Resident Care and Support Services
Medication Management
Responsive Behaviours
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. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee has failed to ensure that a Personal Support Worker (PSW) was included in a CIS report to the Director. A PSW found a resident with an injury. A Nurse Manager (NM) confirmed that the PSW should have been included in the CIS report to the Director.

The CIS report was amended to include the name of the PSW.

Sources: Review of CIS report #M504-000017-25; Interview with a PSW, NM and Registered Nurse (RN).

Date Remedy Implemented: May 16, 2025

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
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 a PSW provided the care set out in a resident's plan of care. The resident's plan of care indicated two staff were to provide assistance with an activity of daily living, which was completed by one staff.

Sources: Home's investigation notes; Resident's care plan; Interview with PSW, NM and Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

i). A resident required assistance when transferring. The resident was transferred inappropriately, when a RPN was present but did not participate in the transfer of the resident with a PSW. The NM stated that the RPN should have been assisting the PSW to ensure resident safety.

ii). The resident was later transferred to the nursing station. The RPN was not present when the resident was transferred. NM stated that the PSW transferred the resident inappropriately.

Sources: Home's investigation notes; Resident's care plan; Interview with RPN and NM.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's skin injury was reassessed weekly. A resident sustained a skin injury. A RPN stated they were unaware that a weekly skin assessment had to be initiated at the time the injury was discovered and acknowledged that a weekly skin assessment should have been completed.

Sources: CIS report #M504-000022-25; Review of the clinical assessments on resident's PointClickCare profile; Interview with RPN and NM.