Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 14, 2013	2013_195166_0001	000959-12,002094-12,000846-12	Critical Incident System

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

Long-Term Care Home/Foyer de soins de longue durée

BENDALE ACRES
2920 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-2T8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 4, 2013

During the course of this inspection, 3 critical incidents were inspected, Log# O-00846-12, Log# O-00959-12, Log# O-002094-12.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care and a Unit Manager.

During the course of the inspection, the inspector(s) reviewed the clinical documentation for 6 residents and reviewed the licensee's policy "Falls Prevention and Management RC-0518-21"

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Falls Prevention

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Log #O-00959-12
Critical Incident report #M504-000032-12 and review of resident #3 clinical documentation confirmed that resident #3, experienced 3 falls in one month, two of the falls occurred on the same day. There was no documented evidence that post fall assessments were completed using a clinically appropriate assessment instrument that is designed specifically for falls.
The licensee failed to ensure that post falls assessments using a clinically appropriate assessment instrument were completed after each fall. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that whenever a resident has fallen, a post fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Log #O-002094-12
Critical Incident #M504-000071-12, review of resident #1 clinical documentation and interview with the unit manager confirmed that resident #1 foot was caught between both foot rests and the floor. When a personal care aide transported resident in the wheelchair the resident's foot became caught causing injury to the resident's leg. The licensee failed to ensure that staff use safe positioning techniques when assisting residents [s. 36.]

Issued on this 14th day of January, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs