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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2014	2014_237500_0023	T-1013-14	Complaint

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

NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 6, 7, 10, 2014.

During the course of the inspection, the inspector(s) spoke with family member, personal care aide (PCAs), registered nursing staff, nurse manager, cook, and nutrition manager.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Food Quality
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A review of resident #24's plan of care and Critical Incident (CI) Report submitted to the Ministry of Health and Long-term Care home revealed that the resident had a fall on an identified day and admitted to the hospital with severe pain in right hip. A review of progress note, indicates that the resident was admitted to the hospital with the diagnosis of hip fracture. Resident returned from the hospital after five days, after the hip surgery was performed.

A review of a CI report indicates that the CI report was first submitted to MOH 9 days after the incident.

Interview with the nurse manager confirmed that the CI report for the above mentioned incident was first submitted 9 days after the incident. The home's practice is that the nurse manager initiates the CI report and the management reviews it before it is submitted to the Ministry. [s. 107. (3)]

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 the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to 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.

A review of a reconciliation order form completed after resident #24 returned from the hospital revealed that the resident was on an identified stool softener, twice a day. A review of the medication administration record for an identified day, revealed that this medication was discontinued after eight months.

Interview with the substitute decision maker (SDM) of the resident confirmed that the home did not inform him/her about the resident receiving the above mentioned medication. The home discontinued the medication after the SDM's request.

Interview with the charge nurse and the nurse manager confirmed that the home needed to conduct meeting with the family, once the resident returned from the hospital, according to the policy. The staff were required to document notes in the progress notes. The charge nurse and the nurse manager confirmed that at the time, the home did not conduct a meeting with the family member after the resident returned from the hospital. The family was not notified about the medication change after the resident returned from the hospital. [s. 6. (5)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system is providing, at a minimum, for standardized recipes for all menus.

A review of a recipe provided in the binder for the cook indicated to use canned cream of celery soup.

Interview with the cook confirmed that the cook is advised to prepare cream of celery soup from scratch. The cook confirmed that the home does not have a standardized recipe to prepare the above mentioned soup from scratch and he/she is using his/her knowledge to prepare it.

Interview with the nutrition manager confirmed that there should be a standardized recipe for cream of celery soup to prepare it from scratch for the cook to use. [s. 72. (2) (c)]

2. The licensee has failed to ensure that the food production system is providing, at a minimum, for preparation of all menu items according to the planned menu.

A review of "Middle Cook Production for Vegetarian Meals to be cooked on Saturdays, 2014 Menu" (as these menus are precooked on Saturdays for next week) revealed that the home should be providing white kidney bean curry on every Tuesday of week one and every Thursday of week 3.

Interview with the cook confirmed that usually, the home does not have white kidney beans ordered and they have to replace it with red kidney beans. For the next day, the cook prepared chick peas instead of white kidney beans curry for vegetarians.

Interview with the nutrition manager confirmed that the kitchen did not have white kidney beans therefore chick peas were prepared instead. [s. 72. (2) (d)]

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Issued on this 12th day of December, 2014

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

Original report signed by the inspector.