Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2019	2019_594746_0019	001574-18, 003588-18, 004884-18, 007719-18, 009660-18, 011167-18, 012435-18, 014941-18, 015310-18, 017714-18, 028322-18, 008513-19, 015526-19, 017560-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

AMANDEEP BHELA (746), CHANTAL LAFRENIERE (194)

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): September 16, 17, 18, 19, 20, 23, 24, 25, 26 and 27, 2019.

Log #001574-18 related to infection control.
Log #003588-18 related to abuse.
Log #004884-18 related to abuse.
Log #007719-18 related to responsive behaviours and abuse.
Log #009660-18 related to responsive behaviours and abuse.
Log #011167-18 related to responsive behaviours and abuse.
Log #012435-18 related to abuse.
Log #014941-18 related to falls.
Log #015310-18 related to responsive behaviours and abuse.
Log #017714-18 related to responsive behaviours and abuse.
Log #028322-18 related to responsive behaviours and abuse.
Log #008513-19 related to injury of unknown cause.
Log #015526-19 related to abuse.
Log #017560-19 related to falls.

During the course of the inspection, the inspector conducted observations on staff to resident interactions, provisions of care, conducted reviews of health records, staff training records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Social Workers (SWs), Behavioural Supports Ontario Lead (BSO), Nurse Managers (NMs), Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
2 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the needs and preferences of the resident.

On an identified date a Critical Incident Report (CIR) for staff to resident physical abuse was submitted to the Director, describing the incident which was reported by resident #022 on an identified date.

Review of the home's internal investigation was completed by Inspector #194 within an identified period of time. The licensee's internal investigation along with resident and staff statements indicted that on an identified date and time resident #022 reported to RN# 109 that the identified staff member had inflicted an injury upon them. RPN #110 and NM #111 involved in the incident are no longer employees of the home, and RPN #110 statements and internal investigation has been used to support the inspection. The internal abuse investigation was unfounded for staff to resident abuse.

The incident report completed by RN #109 on an identified date and time, indicated that during morning report they became aware of the injury to resident #022 and went to assess. During the assessment of resident #022, RN #109 was informed by the resident that the identified staff member had inflicted an injury. RN#109 documented that pain and skin assessments were completed, ice was applied and analgesics were provided for the

resident. Physician and Nurse Manager were notified of the incident.

The RPN #110's internal investigation statement, as well as progress notes were reviewed by Inspector #194 and indicated that RPN# 110 became aware of the injury during provision of care on the identified shift, on the specified date. RPN #110 statement indicated that they asked the resident #022 what had happened and the resident #022 did not respond as they seemed sleepy. RPN# 110 also indicated in their statement that they did not do a complete assessment or provide treatment for resident #022 at that time.

The progress notes on an identified date and time documented by RPN# 110 indicated that resident #022's identified area of injury was slightly swollen and warm to touch.

The resident #022's internal statement, on an identified date indicated the events which took place on the identified shift on the identified date. Resident #022 indicated in their statement that the nurse was informed of the pain.

During interview with Inspector #194 on an identified date and time, related to incident of abuse on an identified date, NM#108 indicated that the home's expectation for a registered staff member who discovers a resident injury would be to complete a skin and pain assessment, provide care as required, complete an internal incident report, document in the progress notes, inform physician next shift.

The licensee failed to ensure that the plan of care was based on an assessment , and the resident's needs and preferences, when RPN #110 did not complete an assessment or provide any treatment for resident #022 when it was discovered that the resident had an injury on an identified date. [s. 6. (2)]

2. The licensee failed to ensure that when resident #024 was reassessed and the plan of care reviewed and revised because the care set out in the plan was not effective, different approaches were considered in the revision of the plan of care.

On an identified date, a Critical Incident Report (CIR), was submitted to the Director, reporting an incident that caused an injury to resident #024 resulting in a transfer to the hospital for further assessment.

Review of the CIR documentation and internal investigation indicated that resident #024 was found on the floor in an identified location on an identified date and time.

Resident was assessed with identified injuries. Resident #024 was transferred to hospital for further assessment. Resident #024 admitted to the hospital with an identified diagnosis and required an identified treatment. Resident #024 returned to the home on an identified date.

Review of the clinical record for resident #024 related to falls, for an identified period was completed by Inspector #194 and indicated;

On an identified date, resident was restless in bed, eventually settled and slept.

On an identified date, at an identified time resident was restless in bed thrusting and turning towards the wall, settled at an identified time.

On an identified date and time, resident was found sitting on the floor mat bedside the bed at an identified time. No injury.

On an identified date and time, resident continued to be restless in bed.

On an identified date and time resident very restless during the shift, attempted to climb out of bed. HS care was provided with resistance. Resident was placed back in wheelchair and put at nursing station for close monitoring.

On an identified date and time resident was assisted to bed at an identified time. At an identified time during rounds resident was found on the floor kneeling beside the bed. No injury.

On an identified date and time resident was monitored during the shift and did not settle in bed. Resident was assisted to mobility device and was observed to be leaning forward trying touch their feet.

On an identified date and time, resident was awake in mobility device at an identified location. Resident restless and agitated, slept on and off in a deep sleep 10-15 min then awake and moving around in mobility device attempting to get out.

On an identified date resident found in TV room, lying on the floor in front of their mobility device at an identified time. Resident was assessed for identified injuries and resident was transferred to hospital for further assessment.

Review of the plan of care for resident #024 related to falls prior to the identified date fall was completed by Inspector #194.

Review of the care plan for resident #024 indicated that no different approaches were considered related to falls post two different identified falls on two different identified dates.

During interview with Inspector #194 on an identified date at an identified time, RN # 100, whom was lead of the Falls Team in the home indicated that registered staff in the home were responsible for updating the plan of care post falls. RN #100 indicated that the Falls Team would review resident falls during the meeting and provide additional interventions if required. RN #100 indicated that falls equipment such as falls mats, body pillows, chair and bed alarms as well as hip protectors were available to all registered staff on the unit.

During interview with Inspector #194 on an identified date at an identified time, RPN #104 indicated that registered staff on the units were responsible for completing, Morse Falls, Skin, Pain and Post Fall Huddle assessments when a resident had a fall. RPN #104 indicated that registered staff were responsible for updating the plan of care for resident's post falls.

During interview with Inspector #194 on an identified date at an identified time, PSW #102 indicated that resident #024 was restless on the evening shift prior to the fall on an identified date. PSW #102 indicated that resident #024 would be placed in mobility device in TV room if unable to settle in bed, where the resident could be monitored by staff.

During interview with Inspector #194 on an identified date at an identified time, NM #101 indicated that the registered staff on the units were expected to review and update the plans of care post fall.

The licensee failed to ensure on two different identified dates when resident #024 was assessed and the plan of care reviewed because the interventions were not effective that different approaches were considered related to falls. [s. 6. (11) (b)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that it's home's policy was complied with.

Review of the licensee's identified policy, was completed by Inspector #194 and indicated specific instructions for staff to follow related to investigation and reporting.

On an identified date, a CIR was submitted to the Director to report an allegation of staff to resident physical abuse involving resident #022 on an identified date.

Review of the CIR indicated that resident #022 sustained an identified injury as reported by the night RPN on the morning of an identified date. The CIR indicated that an amendment was completed to include the outcome of the internal abuse investigation, which was unfounded, on an identified date.

The licensee failed to ensure that the home's policy was complied with, on an identified date when resident #022 reported an allegation of abuse and the MOLTC was not immediately notified and an investigation was not immediately initiated. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

Review of the licensee's internal investigation documentation completed by Inspector #194 indicated that resident #022 reported the allegations of physical abuse to RN #109 on an identified date at an identified time. The internal investigation indicated that the investigation interviews with staff and resident did not commence until, eight days after being reported.

During interview with Inspector #194 on an identified date and time, DOC indicated that it was the responsibility of the Nurse Manager on the unit to initiate the immediate investigation. DOC was unaware of the reason for the delay in the investigation. NM #111 was not available for interview.

The licensee failed to ensure that the reported allegation of staff to resident abuse, by resident #022 on an identified date and time, was immediately investigated. [s. 23. (1) (a)]

2. The licensee failed to report to the Director the results of the abuse investigation.

On an identified date, a CIR, was submitted to the Director to report an allegation of staff to resident physical abuse involving resident #022 on an identified date.

Review of the CIR indicated that resident #022 sustained an identified injury as reported by the night RPN on an identified date. The CIR indicated that an amendment was completed to include the outcome of the internal abuse investigation, which was unfounded, on an identified date.

During interview with Inspector #194 on an identified date and time, DOC indicated that it was the responsibility of the Nurse Manager on the unit to update the CIR's as required with outcome information. DOC was unaware of the reason for the delay in the information. NM #111 was not available for interview.

The licensee failed to report to the Director the results of the abuse investigation involving resident #022 reported to RN #109 on an identified date until an identified date, five months after the incident. [s. 23. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable ground to suspect that abuse of a resident had occurred immediately reported the suspicion to the Director.

On an identified date, a CIR was submitted to the Director to report an allegation of staff to resident physical abuse involving resident #022 on an identified date.

Review of the CIR indicated that resident #022 sustained an identified injury as reported by the night RPN on an identified date.

Review of the internal abuse investigation completed by Inspector #194 indicated that on the identified date and time, RN #109 was provided the information that resident #022 had an injury and went to assess the resident. During the assessment resident #022 informed RN #109 that the identified staff member had caused the identified injury. RN #109 completed the assessment provided analgesic and ice to the resident, notified the physician, completed the internal incident report and notified NM # 111. The CIR was submitted to the Director, on an identified date, 10 days after the reported allegations. There was no evidence to support that the Director was immediately notified.

During interview with Inspector #194 on an identified date at an identified time, DOC indicated that it is the responsibility of the Nurse Manager in the home to complete and submit the CIR's to the Director according to the timelines.

The licensee failed to immediately notify the Director on an identified date when resident #022 reported the allegations of physical abuse to RN #109. [s. 24. (1)]

Issued on this 30th day of October, 2019

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

Original report signed by the inspector.