Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Aug 7, 2020	2020_784762_0015	020192-19, 001134-20, 001152-20, 014488-20	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

MOSES NEELAM (762)

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): July 13-17, 22-24, 27-30, 4-5, 2020

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:
Log related to alleged physical abuse of a resident
Log related to alleged sexual, financial and emotion abuse of a resident
Log related to an incident that lead to the hospitalization of a resident and their subsequent death
Log # 020192-19, follow up to Compliance order (CO) #001, s. 19 (1) related to physical abuse of a resident by a co-resident that lead to the death of a resident, originally issued under inspection #2019_684604_0022, on October 16, 2019, altered by the Director and subsequently issued on December 10, 2019, with a compliance date of February 14, 2020.

PLEASE NOTE: A WN related to section 19(1) is further evidence to support order originally issued on October 16, 2019, altered by Director and subsequently issued on December 10, 2019, during inspection #2019_684604_0022 was to be complied on February 14, 2020.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Supports Ontario Nurse (BSO RPN), Nurse Manager Operations (NMO), Acting Nurse Manager Clinical (ANMC), Director of Nursing (DON), Assistant Administrator (AA), Administrator, Interviewer, Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records, reviewed video footage, reviewed investigation notes and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_684604_0022	762

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #004 that sets out the planned care for the resident.

A critical Incident Report (CIR) was submitted to the Director, regarding the alleged physical abuse of a resident by a staff member. The CIR indicated that PSW #126 had been rough with the resident during care and caused an incident during the provision of care. As noted in the CIR, the incident was a result of PSW #126 not applying a safety mechanism when the resident was on an assistive furniture.

A review of resident #004's electronic medical records, indicated that the resident had the incident on indicated date. A review of the health record for resident #004 indicated that the incident occurred as described in the CIS report. The resident did not sustain any injuries.

The investigation by the Long-Term Care Home (LTCH) concluded that the staff had an elevated tone of voice that requires modulation. Additionally, PSW #126 acknowledged that the safety mechanism was not put on the resident when on the assistive furniture, which "resulted in the resident getting up" and having the incident. The investigation also revealed that the staff member denied being rough and yelling at the resident.

A review of resident #004's electronic medical record, indicated that the resident did not have any written plan of care for the use of the safety mechanism when resident was on the assistive furniture. Additionally, a review of the manual for the assistive furniture, did not indicate the any direction on the use of the safety mechanism.

In separate interviews PSW #120 and # 122 indicated that they would always put on the safety mechanism for the assistive furniture for all residents because it is a general practice in the home. PSW #121, #123 and #125, indicated they would put on the safety mechanism for the assistive furniture for residents who are at risk or cognitively impaired, but not for residents who are cognitively aware. PSW #124 indicated that they would never put on the safety mechanism, as this could be considered a restraint. PSW #126 indicated they did not put on the safety mechanism as they thought it would be considered a restraint, however, now as they have been instructed to do so, they will be putting on the safety mechanism for all residents.

In an interview NMO #103 and NMO #127, indicated the frontline staff are to conduct an

assessment daily and dependent on resident condition the safety mechanism may be applied, if the resident requires a safety mechanism, it will be explicitly stated in the “care plan”. Additionally, resident #004 required the safety mechanism, as they had a history of getting up, and it was not present in the “care plan” or the plan of care.

The licensee has failed to ensure that there is a written plan of care for resident #004 that sets out the planned care for the resident; [s. 6. (1) (a)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #004 from abuse by PSW #107.

A CIR was submitted to the Director which indicated that the family member of resident #004 had cameras placed in resident room and had alleged abuse. A review of the PSW #107's discipline letter, indicated the staff abused resident #004 on multiple different occasions.

A review of a sample of three video clips shows the staff member abusing the resident.

A review of investigation notes conducted by Interviewer #128 and AA #110 was reviewed. In these notes PSW #107 acknowledged having inappropriate physical contact with resident #004.

In an interview Administrator #129, indicated that PSW #107 had inappropriate physical contact with resident #004, and that this was inappropriate. Administrator #129 stated that the LTCH viewed this as abuse.

The licensee failed to protect resident #004 from abuse by PSW #107. [s. 19. (1)]

Issued on this 10th day of August, 2020

[redacted]

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

Original report signed by the inspector.