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 19, 2021	2021_882760_0029	009365-21, 010000-21, 011023-21, 011114-21, 011178-21, 011596-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street 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

JACK SHI (760)

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): August 10, 11, 12, 13, 16, 17, 2021.

The following intakes were completed in this critical incident inspection:

Four logs were related to a fall;
A log was related to an allegation of resident abuse;
A follow up log related to to Compliance Order (CO) #001, LTCHA, s. 20 (1), related to prevention of resident abuse, issued under inspection #2021_598570_0013, on June 9, 2021, with a compliance due date of July 9, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with a Nursing Clerk, the Manager of Building Services, Activation Aides, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Managers (NM), the Assistant Administrator (AA) and the Administrator.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, reviewed home's air temperature monitoring logs, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. 20. (1)	CO #001	2021_598570_0013	760

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. As part of this directive, dated July 14, 2021, the following has been issued to Long-Term Care Homes:
- All staff and visitors are to comply with universal masking policies.
- Homes shall develop infection prevention and control (IPAC) protocols and policies, including the use of personal protective equipment (PPE).

The following observations were made in the home:

- Two PSWs and a visitor were observed to have their masks worn below their nose while they were on resident care areas in the home or was interacting with a resident. A nurse manager stated the home's universal masking policy would be to ensure that the mask covers their nose.
- A resident was identified by staff to be on precautions but signage was not placed on the resident's room door. The NM stated that the signage should be posted in front of the resident's room door.
- A resident had signage outside their room indicating they were on precautions, however, there were no gloves available in the caddie hanging outside their door. An RPN stated gloves should be stocked in the PPE caddie when the staff have used the last one.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and a visitor of the home. Failure to follow the IPAC measures stated in Directive #3 may result in possible transmission of infectious agents.

Sources: Directive #3, dated July 14, 2021; Interviews with a nurse manager, an RPN and other staff; Observations made throughout the home during the inspector's inspection. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in one resident common area on every floor of the home, in July 2021.

Bendale Acres is a long-term care home with six resident floor units. A review of the home's air temperature monitoring records for July 2021 indicated that air temperatures were being recorded in resident rooms, but not in common resident areas of the home. The Assistant Administrator stated that from a date in August 2021, the home initiated recording of the air temperatures electronically in the required locations and prior to that, the air temperatures recorded did not meet the requirements of the legislation. Failure to monitor the air temperatures in the common areas may result in an uncomfortable environment for residents.

Sources: Review of temperature readings from the home in July 2021; Interview with the Assistant Administrator and other staff. [s. 21. (2) 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 the temperature is measured and documented in writing, at a minimum in the following areas of the home: 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor., to be implemented voluntarily.

WN #3: 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. The licensee failed to ensure that an RPN and an RN used safe transferring techniques following the fall of a resident.

According to the progress notes, the resident had a fall and staff had performed a transfer on the resident. The resident had a change in their condition later that day and was diagnosed with an injury. An RPN stated that with the RN, they had performed a transfer on the resident. A nurse manager stated that the staff should not have used this transfer technique on the resident. The use of this transfer technique may have further aggravated the resident's injury.

Sources: A resident’s progress notes; Interviews with an RPN, a nurse manager and other staff. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's fall prevention intervention was maintained in a good state good of repair.

A review of the resident's progress notes and care plan indicated after the resident's first fall, fall prevention interventions were implemented. The resident sustained a second fall and the RPN stated that a fall prevention intervention used for this resident was not working at the time of this resident's second fall. Another RPN stated they had noticed this resident's fall prevention intervention was not working at the start of their shift, but did not replace it until after the resident sustained their fall. The use of this fall prevention intervention may have prevented this resident's fall and any potential injuries.

Sources: A resident's care plan, progress notes; Interviews with two RPNs and other staff. [s. 15. (2) (c)]

WN #5: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a fall prevention equipment readily available in the home when it was implemented for a resident.

According to the progress notes, the resident sustained a fall and subsequently, the interdisciplinary team in the home implemented fall prevention interventions.
The RN emailed the nursing clerk to provide the fall prevention equipment for the resident, but was told that there were none that could be provided. The nursing clerk stated that the available equipment that the RN requested for this resident was not in a working condition, therefore they had to order new ones. Days after, the resident received their fall prevention equipment. A nurse manager stated that the home's expectation would be to have readily available fall prevention equipment for residents who are at high risk for falls. Failure to have fall prevention equipment readily available may result in further falls in residents along with potential injuries.

Sources: A resident's progress notes, care plan; Interview with an RN, a nursing clerk, a nurse manager and other staff. [s. 49. (3)]

Issued on this 24th day of August, 2021

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

Original report signed by the inspector.