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
Apr 4, 2022	2022_882760_0007	014324-21, 002135-22	Complaint

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), CATHERINE OCHNIK (704957)

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): March 11, 14, 15, 16, 17, 18, 21, 2022.

The following intakes were completed in this complaints inspection:

A log was related to falls and change in condition;
A log was related to dining room services.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Nutrition Manager, the Physiotherapist (PT), and Nurse Managers (NM).

During the course of the inspection, the inspector toured the home, care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee failed to ensure a resident received end-of-life care that met their needs.

A complaint was submitted to the Ministry of Long-Term Care related to concerns that end-of-life care was not properly provided to a resident. The resident had a change in condition and started to decline. An assessment was completed when they initiated had their change in condition. The assessment determined the resident was not eligible for end-of-life care. This assessment was not repeated, despite the resident's continued decline, until a few days after, where it was determined the resident was eligible for end-of-life care. However, the resident deceased on that same day.

An RN and Nurse Manager (NM) indicated that more assessments should have been completed when the resident had a gradual decline in their condition, to ensure that end-of-life care can be initiated as soon as the resident would become eligible. The NM confirmed the staff failed to ensure that the end-of-life care was appropriately provided.

Sources: Interview with an RN and NM and other staff; review of the home's end-of-life policy; Review of the resident's progress notes. [s. 42.]

Issued on this 5th day of April, 2022

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

Original report signed by the inspector.