Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Public Report

Report Issue Date: July 15, 2025

Inspection Number: 2025-1531-0005

Inspection Type:
Critical Incident
Follow up

Licensee: City of Toronto

Long Term Care Home and City: Bendale Acres, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3, 4, 7-10, 14, 15, 2025

The inspection occurred offsite on the following date(s): July 14, 2025

The following intake was inspected in this Follow-Up inspection:

- Intake: #00147447 - related to a previously issued compliance order related to dining and snack service

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00147745 [CI: M504-000030-25] - related to neglect of a resident
- Intake: #00148532 [CI: M504-000033-25] - related to abuse of a resident
- Intake: #00148542 [CI: M504-000034-25] - related to a fall of a resident resulting in injury
- Intakes: #00149109 [CI: M504-000036-25] and #00149489 [CI: M504-000037-25] - related to an injury of unknown cause sustained by a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1531-0003 related to O. Reg. 246/22, s. 79 (1) 9.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff involved in a resident's care collaborated in the assessment of the resident so that their assessments were consistent with and complemented each other. A Registered Nurse (RN) discovered

an altered skin integrity on a resident that they assessed. There were no prior assessments of any altered skin integrity despite the area having received previous treatment. A Registerd Practical Nurse (RPN) had not observed the resident's altered skin integrity, but documented the RN's assessment. The next day, the RPN edited the same assessment to document a different assessment.

Sources: A resident's clinical records; and Interviews with an RPN and RN.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that an RN collaborated with the registered staff in the implementation of the resident's plan of care. Specifically, the RN did not communicate to the registered nursing staff that the resident required a diagnostic test as ordered by the physician. The registered nursing staff did not provide an update to the prescribing physician, and there was no follow-up with the external service company to arrange to have the diagnostic test completed until 21 days later.

Sources: A resident's clinical records and interview with an RN.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan. A resident's plan of care directed staff to place the height of their bed to be in a specified position. An observation showed the bed was not in the specified position while the resident was in bed.

Sources: Observations; a review of the resident's plan of care; and interview with a Personal Support Worker (PSW).

WRITTEN NOTIFICATION: General Requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound care program including assessments, reassessments, interventions and the resident's responses to interventions were documented. Specifically, an RN found an altered skin integrity with a treatment in place on a resident, that was not included in the resident's plan of care. There were no

documented assessments or interventions related to any altered skin integrity to this area prior to this date.

Sources: A resident's clinical records; Home's policy related to skin care and wound prevention and management; Interviews with a PSW, an RN, and a nurse manager.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee has failed to ensure staff complied with the home's responsive behaviour policy related to resident monitoring and reporting protocols, when they failed to complete a referral to the Behavioural Support Ontario (BSO) team for a resident exhibiting responsive behaviours.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that resident monitoring and internal reporting protocols were developed to meet the needs of residents with responsive behaviours and ensure they were complied with.

Specifically, staff did not complete and submit referrals to the BSO team following incidents of a resident's responsive behaviours on 13 occasions between two specified dates.

Sources: A resident's clinical records, LTCH policy related to behavioural response - care strategies, and code white - violent/aggressive behaviour; and interview with the BSO Lead.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were implemented to respond to a resident's responsive behaviours.

A resident had a history of responsive behaviours towards others. The strategy of having two staff present to provide care to the resident was not implemented, when a PSW entered the resident's bathroom by themselves, which resulted in the resident exhibiting responsive behaviours and harming themselves in the process.

Sources: A resident's clinical records; and an interview with a PSW.