

**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**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de
Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 9, 2021	2021_598570_0013	004957-21, 005175- 21, 005176-21, 005342-21, 005495-21	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

SAMI JAROUR (570)

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): May 4, 5, 6, 7, 10, 11, 2021.

The following intakes were completed in this critical incident inspection:

Log #004957-21, related to a fall incident;

Logs #005175-21, #005176-21 and #005342-21, related to allegations of resident abuse;

Log #005495-21, follow up to CO #001 issued on March 31, 2021, within inspection report #2021_838760_0010, related to O. Reg. 79/10, s. 229 (4).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Prevention of Abuse, Neglect and Retaliation

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

4 WN(s)

2 VPC(s)

1 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 # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2021_838760_0010		570

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
<p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: 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 has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with.

A review of the home's policy titled zero tolerance of abuse and neglect, revealed that it is the responsibility of all staff to inform the RN/RPN immediately on becoming aware of any and every alleged, suspected or witnessed incidents of abuse or neglect in order to commence an immediate investigation and reporting.

Two critical incident system reports (CIR) were submitted to the Ministry of Long-Term Care (MLTC) related to two incidents of alleged abuse of residents #004 and #006 which occurred four days prior.

During an interview, PSW #109 indicated they witnessed PSW #107 being rough with residents #004 and #006 during care. The PSW indicated they did not immediately report the incidents to the registered staff on the unit and that they reported the incidents to the nurse manager (NM) #115 after four days.

During an interview, NM #115 indicated they become aware of the allegations involving residents #004 and #006, four days after it was witnessed by PSW #109. The NM indicated that PSW #109 should have immediately reported abuse allegations to registered staff on the unit.

By failing to comply with the home's policy of zero tolerance of abuse and neglect and immediately report allegations of abuse, residents were at risk of abuse as no immediate actions were taken.

Sources: CIR reports, the home's investigation notes, interviews with PSW #109 and NM #115. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

Two critical incident system reports (CIR) were submitted to the Ministry of Long-Term Care (MLTC) related to two incidents of alleged abuse of residents #004 and #006 which occurred four days prior.

During an interview, PSW #109 indicated they witnessed PSW #107 being rough with residents #004 and #006 during care.

A review of the home's investigation notes and an interview with NM #115 indicated PSW #107 was found to be rough with residents #004 and #006 when provided care to both residents.

Residents #004 and #006 were at risk of harm when their rights to be treated with respect and dignity were not promoted during the provision of care by PSW #107.

Sources: Critical Incident System reports, the home's investigation notes, interviews with PSW #109 and NM #115. [s. 3. (1) 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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

**WN #3: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care was provided to the resident as specified in the plan.

The MLTC received a critical incident system report (CIR) regarding resident #001, who sustained a fall with injury.

A review of clinical records for resident #001 indicated the resident was at risk for falls. The resident sustained multiple unwitnessed falls in a two month period.

A review of the current plan of care for resident #001 indicated that the resident was to have a specified intervention for falls on every shift.

Observations on two consecutive days by Inspection #570, revealed that a specified falls prevention intervention was not in place for the resident.

During interviews, PSW #112 and RN #101 confirmed that on specified date, resident #001 did not have the specified intervention for falls prevention in place; On the following day, PSW #105 and RN #106 confirmed that resident #001 did not have the specified intervention for falls prevention in place.

During an interview, Nurse Manger (NM) #104 indicated resident #001 should have a specified intervention for falls prevention in place as directed in the written plan of care.

By not ensuring resident #001's plan of care was provided to the resident as specified in the plan, they were placed at risk of not having their care needs met as required.

Sources: Plan of care and clinical records for resident #001, interviews with PSW #105, PSW #112, RN #101, RN #106 and NM #104. [s. 6. (7)]

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 provided to the resident as specified in the plan, to be implemented voluntarily.

**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 has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident by staff that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it was based to the Director.

Critical incident system report (CIR) was submitted to the MLTC related to an incident of alleged abuse of resident #004.

During an interview, PSW #109 indicated they witnessed PSW #107 being rough with resident #004 during care. The PSW indicated they did not immediately report the incident to the registered staff on the unit and that they reported the incident NM #115 four days after they witnessed the incident.

During an interview, NM #115 indicated they did not immediately report the allegation to the Director until the following day.

Sources: CIR report, the home's investigation notes, interviews with PSW #109 and NM #115. [s. 24. (1)]

Issued on this 11th day of June, 2021

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

Original report signed by the inspector.

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SAMI JAROUR (570)

Inspection No. /

No de l'inspection : 2021_598570_0013

Log No. /

No de registre : 004957-21, 005175-21, 005176-21, 005342-21, 005495-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Jun 9, 2021

Licensee /

Titulaire de permis : City of Toronto
Seniors Services and Long-Term Care (Union Station),
c/o 55 John Street, Toronto, ON, M5V-3C6

LTC Home /

Foyer de SLD : Bendale Acres
2920 Lawrence Avenue East, Scarborough, ON,
M1P-2T8

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Gina Filice

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

To City of Toronto, you are hereby required to comply with the following order(s) by
the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # /

No d'ordre : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCH Act.

Specifically, the licensee must:

1. Educate all staff on a specified residents' home area on the licensee's policy "zero tolerance of abuse and neglect".
2. Test the staff knowledge of the definitions of abuse and the reporting requirement of abuse allegations and keep a documented record of the process.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with.

A review of the home's policy titled zero tolerance of abuse and neglect, revealed that it is the responsibility of all staff to inform the RN/RPN immediately on becoming aware of any and every alleged, suspected or witnessed incidents of abuse or neglect in order to commence an immediate investigation and reporting.

Two critical incident system reports (CIR) were submitted to the Ministry of Long-Term Care (MLTC) related to two incidents of alleged abuse of residents #004 and #006 which occurred four days prior.

During an interview, PSW #109 indicated they witnessed PSW #107 being rough with residents #004 and #006 during care. The PSW indicated they did not immediately report the incidents to the registered staff on the unit and that

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

they reported the incidents to the nurse manager (NM) #115 after four days.

During an interview, NM #115 indicated they become aware of the allegations involving residents #004 and #006, four days after it was witnessed by PSW #109. The NM indicated that PSW #109 should have immediately reported abuse allegations to registered staff on the unit.

By failing to comply with the home's policy of zero tolerance of abuse and neglect and immediately report allegations of abuse, residents were at risk of abuse as no immediate actions were taken.

Sources: CIR reports, the home's investigation notes, interviews with PSW #109 and NM #115.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents.

Scope: The scope of this non-compliance was a pattern; non compliance was found in two out of three incidents inspected.

Compliance History: a Voluntary Plan of Correction (VPC) was previously issued under s.20 (1) in the past 36 months. (570)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Jul 09, 2021

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
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Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
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2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of June, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Sami Jarour

Service Area Office /

Bureau régional de services : Central East Service Area Office