Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 12, 2017	2017_420643_0011	003407-17	Follow up

Licensee/Titulaire de permis

TENDERCARE NURSING HOMES LIMITED
212 Queen Street East, Suite 202 Sault Ste Marie ON P6A 5X8

Long-Term Care Home/Foyer de soins de longue durée

TENDERCARE LIVING CENTRE
1020 McNICOLL AVENUE SCARBOROUGH ON M1W 2J6

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

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 6-9, 12-16, and 19-22, 2017.

This Follow up inspection was conducted related to Compliance Order #001 under inspection report #2016_430644_0012 related to safe transferring and positioning techniques.

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

During the course of the inspection the inspector observed the provision of care, staff to resident interactions, reviewed relevant policies and procedures and staff training records.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **1 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	Legendé 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. 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 license has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Two Compliance Orders were served under inspection report #2016_302600_0001 issued February 8, 2016, and #2016_430644_0012 issued February 7, 2017, related to

staff use of safe transferring and positioning techniques when assisting residents. Compliance Order #001 under inspection report #2016_430644_0012 directed the licensee to prepare, submit and implement a plan to achieve compliance in the area of safe transferring and positioning techniques. The licensee was ordered to ensure staff complied with the home's policies and procedures and individual resident plans of care, provide education to direct care staff on safe transferring and positioning techniques and to develop a system to audit staff adherence with the home's policies and procedures and individual resident plans of care. The home was ordered to be in compliance by March 29, 2017.

a. Review of a Critical Incident System report (CIR) submitted to the Ministry of Health and Long-Term Care (MOHLTC) revealed that on an identified date, resident #003 was found by RN #124 to have an identified injury with an unknown origin. It was reported to RN #124 by family members that they believed PSW #123 was rough with resident #003.

Record review of resident #003's health records revealed that he/she had identified medical diagnoses. Review of resident #003's written plan of care from an identified date, revealed that he/she required the assistance of two staff members using an identified mechanical lift for transferring. Resident #003's written plan of care stated he/she was to be toileted by transferring with another mechanical lift.

Review of the home's policy titled "Safe Lifting with Care Program" document number 01-03 revised May 2009, section titled "Mechanical Lifts" revealed that all transfers using a mechanical lift are to be performed by two staff members for the safety of both resident and staff members.

In an interview PSW #123 stated that resident #003 is transferred using an identified mechanical lift and requires the assistance of two staff members for transfer. PSW #123 indicated that on an identified date that he/she had transferred resident #003 without another staff member to assist him/her. PSW #123 further stated that he/she was unable to find another staff member to assist with resident #003's transfer at the time.

Review of resident #003's current written plan of care on an identified date during the inspection, revealed that he/she had been assessed by Physiotherapist (PT) #110 one month prior, and the care plan was changed to reflect that resident #003 would no longer be toileted using the above mentioned mechanical lift. Staff were instructed to provide personal care to resident #003 in bed.

In an interview on an identified date, PSW #112 stated that resident #003 was transferred using an identified mechanical lift with the assistance of two staff members. PSW #112 further stated that resident #003 was to be toileted using the other identified device, with the assistance of two staff members. PSW #112 stated that he/she was unaware that resident #003's plan of care had changed and did not use the other above mentioned mechanical lift for toileting. PSW #112 stated he/she was the full time staff providing care for resident #003 and had been using the above mentioned mechanical lift for toileting up until the date of the interview.

In an interview, the DOC acknowledged that by transferring resident #003 without the assistance of another staff member, PSW #123 had not used a safe transferring technique while assisting the resident. The DOC additionally acknowledged that PSW #112 had not been using safe transferring techniques to assist resident #003 with toileting. The DOC acknowledged that in this case the licensee had failed to ensure that staff had used safe transferring techniques to assist resident #003.

b. Review of a CIR submitted to the MOHLTC on an identified date, revealed that PSW #116 had been observed by RPN #132 to have performed an improper method of toileting resident #002.

Review of resident #002's plan of care accessed on an identified date, revealed that resident #002 was to be toileted by an identified method. He/she was to be transferred by two staff members using an identified mechanical lift for toileting.

In an interview with inspector #501, RPN #132 stated that he/she had observed resident #002 in an identified transfer device in an identified position. RPN #132 stated that there were no staff members in the room at the time. RPN further stated that PSW #116 told him/her that resident #002 was left in the above mentioned device to aid with toileting.

In an interview with inspector #501, PSW #116 stated that he/she would leave resident #002 in the identified position. PSW #116 further stated that he/she would leave resident #002 there for 5-10 minutes while in the identified transfer device. PSW #116 stated that he/she had done this three times.

In an interview with inspector #501, resident #002 stated that he/she had been left in the identified transfer device for half an hour by PSW #116 because someone else needed PSW #116's help. Resident #002 further stated that he/she was uncomfortable in the identified transfer device and that this had occurred twice.

Review of the home's policy titled "Safe Lifting with Care Program" document number 01-03 revised May 2009, section titled "Mechanical Lifts" revealed that for use of a ceiling lift staff are to remain with the resident during the entire time the sling is connected to the mechanical lift. The policy additionally required two people at all times when operating a lift.

In an interview, PT #152 stated that leaving a resident in the identified transfer device is not a safe transferring technique. He/she further stated that a resident should be in the identified transfer device for the shortest time possible to safely complete the transfer. PT #152 stated that two staff members should assist residents with transferring using a mechanical lift until transferring is completed.

In an interview, the DOC acknowledged that this method of toileting resident #002 was not safe. He/she stated that the resident should not be in the identified transfer device any longer than needed. The DOC additionally stated that the transfer was not completed until the resident was repositioned and the identified transfer device was removed. The DOC acknowledged that the licensee had failed to ensure that staff had used safe transferring techniques for resident #002.

c. On February 7, 2017, the home received Compliance Order #001 during the Resident Quality Inspection #2016_460644_0012. The grounds for issuing order #001 were that PSWs #109 and #105 did not use safe transferring and positioning techniques when assisting residents. The order directed the home to ensure that staff use safe transferring and positioning techniques when assisting residents who require assistance with transfers. Part of the order was to provide education to all direct care staff in regards to different types of transfer methods used with residents and the manner in which the methods are used to ensure safety. The home was to be in compliance by March 29, 2017.

Review of the home's records for the online Safe Lifting with Care Program revealed that 94 per cent of staff had completed the online training module upon inspection on June 6, 2017. Review of in-person training records revealed that 152 of 194 direct care staff members had received the training as of June 6, 2017. Records revealed that 22 per cent of direct care staff did not receive the in-person training on safe transferring techniques.

In an interview, the ADOC stated that training was provided to direct care staff in two

forms, by online learning module, and in-person training provided by PSW champions who were trained to provide the training to the other staff. Staff were to be trained online using the Extendicare Safe Lifting with Care Program Education Module covering mechanical lifts. Staff were to additionally be trained in a hands-on in-person session in which the different lifts and manual transfer methods would be demonstrated. The ADOC acknowledged that the home had not fully completed the staff training ordered by Compliance Order #001 under inspection report #2016_430644_0012.

The severity of this finding is potential for harm related to failure to ensure that staff used safe transferring and positioning techniques when assisting residents. The scope is isolated to two residents, and 22 per cent of staff who did not receive the required education. Review of the home's compliance history revealed that on February 8, 2016, under inspection report #2016_302600_0001 a Compliance Order had been served with a compliance due date of February 19, 2016. On February 7, 2017, a second Compliance Order had been served with a compliance due date of March 29, 2017. As a result of two previous compliance orders having been served and continued noncompliance with O. Reg. 79/10, s. 36, a Director's Referral is warranted. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 24th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2017_420643_0011
Log No. / Registre no:	003407-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 12, 2017
Licensee / Titulaire de permis :	TENDERCARE NURSING HOMES LIMITED 212 Queen Street East, Suite 202, Sault Ste Marie, ON, P6A-5X8
LTC Home / Foyer de SLD :	TENDERCARE LIVING CENTRE 1020 McNICOLL AVENUE, SCARBOROUGH, ON, M1W-2J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Francis Martis

To TENDERCARE NURSING HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_430644_0012, CO #001;

Pursuant to / Aux termes de :

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.

Order / Ordre :

Upon receipt of this compliance order the licensee shall:
1. Identify all residents of the home who require the use of a mechanical lift for transferring.
2. Review each resident's identified transfer method with all direct care staff.
3. Complete previously ordered training under inspection report #2016_430644_0012:
Provide education to remaining 22 per cent of direct care staff on the home's lift and transfer policies, and safe transferring methods for mechanical lifts used in the home.

Grounds / Motifs :

1. The license has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Two Compliance Orders were served under inspection report #2016_302600_0001 issued February 8, 2016, and #2016_430644_0012 issued February 7, 2017, related to staff use of safe transferring and positioning techniques when assisting residents. Compliance Order #001 under inspection report #2016_430644_0012 directed the licensee to prepare, submit and implement a plan to achieve compliance in the area of safe transferring and positioning techniques. The licensee was ordered to ensure staff complied with the home's policies and procedures and individual resident plans of care, provide education to direct care staff on safe transferring and positioning techniques and to develop a system to audit staff adherence with the home's policies and procedures and individual resident plans of care. The home was

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

Service Area Office /
Bureau régional de services : Toronto Service Area Office