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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 5, 2018	2018_684604_0012	024469-18	Resident Quality Inspection

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

SHIHANA RUMZI (604), ROMELA VILLASPIR (653), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, and 28, 2018.

The following intakes were completed:

-Complaint intake# #002776-18, related to improper transfer and fall

-Intake #004466-18, related to follow-up Order #001 served on February 27, 2018, under s. 6 (7) related to to plan of care

-Intake #004465-18, related to follow-up Order #002 served on February 27, 2018, under r. 36 related to safe positioning and transfers.

-Intake #004604-18, related to the follow-up Order #003 served on February 27, 2018, under r. 50 (2) related to skin and wound care

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Translators, Registered Nurses (RN), Registered Practical Nursee (RPN), Quality Care Nurse (QCN), Personal Support Workers (PSW), Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Coordinator, Dietary Manager (DM) Food Services Supervisor (FSS), Social Worker (SW), Residents' Council Assistant (RCA), Dietary Aide (DA), Ward Clerk (WC), Registered Dietitian (RD) Physiotherapist (PT), Residents, Substitute Decision Makers (SDMs), and Presidents of the Residents' Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: medication administration and storage area, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant policies and procedures.

Inspectors Adelfa Robles #723 was shadowing.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care
Snack Observation

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

- **5 WN(s)**
- **4 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
O.Reg 79/10 s. 36.	CO #002	2018_642606_0001	570
O.Reg 79/10 s. 50. (2)	CO #003	2018_642606_0001	653
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_642606_0001	570

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation have been instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 50 (1) (4) the skin ad wound care program must, at a minimum, provide treatments and interventions, including physiotherapy and nutrition care.

A review of the home's policy #RC-23-01-01 titled "Skin and Wound Program: Prevention of Skin Breakdown", with the last updated date as February 2017, indicated the following under ongoing procedures:
-For residents assessed with a Pressure Ulcer Risk Scale (PURS) score of four or greater or otherwise identified at risk of altered skin integrity (e.g. residents requiring assistance to transfer, diabetics) staff are to complete a referral to other members of the interdisciplinary (which may include but is not limited to the Dietitian, Occupational Therapist, Physiotherapist or others as appropriate).

Resident #008 triggered through stage one of the RQI for new/worsening alteration in skin condition through the census record review.

A review of resident #008's written plan of care with an identified review date indicated the resident required two person physical assist for all transfers and also required the wheelchair for all mobility needs.

A review of resident #008's identified assessment indicated the resident had alteration in skin in an identified area and treatment was ongoing.

Inspector #653 conducted an observation on an identified date and time with PSW #117 and Registered Practical Nurse (RPN) #118 for resident #008. The Inspector and the staff members noted an area of alteration in skin condition.

Interviews were conducted with RPN #118 and Registered Nurse (RN) #131 and both RPN and RN indicated an identified skin condition was considered as an alteration in skin integrity. The RPN acknowledged that resident #008 has skin integrity concerns. Both the RPN and RN indicated that the registered staff did not send a dietary referral at the time the alteration was noted, however, if the alteration in skin condition remained and is not

healing after three to four days, then a referral to the RD would be sent.

An interview was conducted with the RD who indicated they were unaware of the resident #008's altered skin integrity on an identified area. The RD further indicated they would have expected a dietary referral from the registered staff, given resident #008's history of alteration in skin condition. The RD further acknowledged they had not received a referral for resident #008's alteration in skin condition.

An interview was conducted with the Director of Care (DOC) who acknowledged the above mentioned information and further indicated that the registered staff should have submitted a referral to the RD following the skin assessment for resident #008 which was carried out on an identified date when the resident was identified to have an alteration in skin condition in an identified location. The DOC acknowledged the home's policy had not been complied with due to the absence of referral to the RD.

2. According to O. Reg. 79/10, s. 50 (1) (4) "The skin and wound care program must, at a minimum, provide for the following: Treatments and interventions, including physiotherapy and nutrition care".

A review of the home's policy #RC-23-01-01, titled "Skin and Wound Program: Prevention of Skin Breakdown" with the last updated date as February 2017, indicated under interdisciplinary wound care team roles that nurse performs treatments and dressing changes as per treatment orders on Treatment Administration Record (TAR)/ElectronicTreatment Administration Record (eTAR).

Resident #003 triggered through stage one of the RQI for alteration in skin condition from the staff interview and census record review.

A review of resident #003's identified assessment carried out on an identified date indicated the resident had an alteration in skin condition in an identified location.

A review of resident #003's physician orders on Point Click Care (PCC) and eTAR for an identified month, indicated the treatment for the alteration in skin condition.

Inspector #653 conducted a treatment observation for resident #003 with by RN #119 on an identified date time. The RN removed the resident's identified clothing and the Inspector and RN noted that there was no identified treatment applied to the alteration in skin condition. The RN carried out the treatment as per the eTAR order.

In an interview was conducted with RN #119 who acknowledged that the home's policy had not been complied with as there was no treatment applied on resident #003's identified area of alteration in skin condition before the RN applied the new treatment.

An interview was conducted with the DOC who indicated the application of the identified treatment was the nurse's responsibility, and the PSW should report to the nurse if the treatment was missing. The DOC further acknowledged that the home's policy had not been complied with, when the previous treatment was not found on the identified area of alteration in skin condition prior to the treatment change on an identified date.

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 ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

The licensee had failed to ensure that the planned menu items were offered and available at each meal.

Resident #010 triggered through stage one of the Resident Quality Inspection (RQI) for an identified change in health status.

Inspector #653 conducted an identified meal observation for resident #010 on an

identified date, time, and location of the home and noted the following:
-At the beginning of the meal service, Personal Support Worker (PSW) #120 offered and provided an identified fluid to resident #010. Throughout the meal service, the Inspector did not observe the Dietary Aide (DA) or the nursing staff offering other identified fluids resident #010.

A review of the home's therapeutic menu identified 250 milliliters (ml) of an identified fluid is to be offered at every meal for all residents unless otherwise specified in the residents written plan of care.

A review of resident #010's written plan of care with an identified review date did not identify the identified fluid as a dislike.

An interview was carried out with DA #114 and PSW #120 at 1433hrs, both staff members acknowledged resident #010 was not offered the identified fluid and the PSW indicated that resident #010 only received an identified fluid. A further interview with PSW #120 indicated that the DA is to offer an identified fluid to residents in a big glass, however, if a resident asks the PSW for the identified fluid, then the PSW would provide it to the resident.

2. Due to an area of non-compliance identified related to planned menu items not offered and available at each meal, the sample size was expanded and another meal observation was carried out.

Inspector #653 conducted an identified meal service observation on an identified date, time and location of the home. The posted Spring Summer 2018, week three regular fluid options were identified.

During the meal observation the Inspector made the following observations:
-At an identified time DA #122 was observed providing fluids to the residents and the Inspector noticed there was no pitcher of an identified fluid on the drink cart. DA #122 placed a glass of an identified fluid on resident #013's table, which the resident drank immediately and at an identified time, PSW #126 offered and provided the resident with another identified fluid.
-At an identified time PSW #123 offered and provided an identified fluid to resident #014.
-Throughout the meal service the Inspector did not observe the DA or the nursing staff offering two identified fluids as indicated and posted on the Spring Summer 2018, menu to residents #013 and #014.

A review of the home's therapeutic menu had identified two fluids which were to be offered at every meal, and an identified fluid was to be offered on an identified date during an identified meal to all residents.

An interview was conducted with PSW #123, who indicated that they only offered only an identified fluid to resident #014 during the identified meal service.

An interview was conducted with DA #122, who acknowledged the above observations and indicated that an identified fluid was usually on the cart and is to be offered by the PSW's. The DA also acknowledged that an identified fluid from the posted Spring Summer 2018, menu was not available on the cart during an identified meal service and it was not offered to the residents.

An interview was conducted with PSW #126 who indicated resident #013 always refuses an identified fluid and the PSW denied not offering the identified fluid to the resident during the Inspector's observation.

A review of resident #013's written plan of care with an identified review date and resident #014's written plan of care with an identified date was reviewed and both written plans of care did not identify two of the identified fluids on the posted menu as a dislike.

During separate interviews with the Food Services Manager (FSM) #121 and with the Registered Dietitian (RD) #128 both acknowledged the above observation and further indicated an identified fluid is to be offered at all meals as per the therapeutic menu and the RD further indicated that the home has to meet Canada's food guides servings for an identified fluid with a recommended serving per day. The RD stated unless otherwise indicated in the written plan of care, it is the home's expectation that the staff offer planned menu items to all residents. The FSM further indicated that the DA should have had the posted menu items available on their cart, and offered it as per the planned menu. Both the FSM and RD acknowledged that the planned menu items were not offered and available at an identified meal service.

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 ensure that the planned menu items were offered and available at each meal, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee had failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On an identified date and time Inspector #604 and #723 with the assistance of a Translator #102 conducted a stage one interview with resident #001. The resident indicated they take an identified medication daily for an identified health condition. The resident proceeded to take out an identified medication from an identified location. The resident indicated that their family purchases the identified medication and has self-administered the identified medication for the past several months.

Inspector #604 conducted an interview with RN #103 who stated that as per the home's policy medications are to be stored in the medication cart that is locked. The Inspector and the RN went to resident #001 who was in an identified location of the home in the presence of the Translator and Inspector #723. The RN was shown the identified medication which the resident was holding. The RN acknowledged that the resident had an identified medication with them and it was not stored appropriately and it should be locked.

Inspector #604 conducted an interview with Associate Director of Care (ADOC) #104 for an identified location of the home. The ADOC stated that all medications are to be stored in a medication cart that is to be locked. The ADOC was informed of the above observations for resident #001 and they acknowledged that the identified medication was not appropriately stored.

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 ensure that drugs were stored in an area or a medication cart that was secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee had failed to ensure that no drugs were used by a resident in the home, unless the drug where prescribed for the resident.

On an identified date and time Inspector #604 and #723 with the assistance of a Translator #102 conducted a stage one interview with resident #001. The resident indicated they takes an identified medication daily for an identified health condition. The resident proceeded to take out an identified medication from an identified location. The resident indicated that their family purchases identified medication and has self-administered the identified medication for the past several months.

Inspector #604 conducted separate interviews with RN #103 and ADOC #104. The RN and ADOC stated as per the home's policy there is to be a physician order for all medications being administered to residents in the home. The RN and ADOC reviewed resident #001's physician orders and acknowledged that the resident did not have an order for the identified medication, however had been self-administering them.

2. The licensee had failed to ensure that drugs had been administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #653 followed-up on CO #003, related to alteration in skin condition. Three residents who had triggered to stage two, were chosen as the sample size. One of the residents that had been chosen was resident #012.

A review of resident #012's identified weekly skin assessments with two identified dates indicated the resident had two areas of alteration in skin condition. A review of resident #012's three month medication review signed by the physician on an identified date and the eTAR record for an identified moth, indicated identified treatments for the alteration in skin condition

Inspector #653 conducted an identified treatment observation for resident #012 on an identified date and time, with RN #11. The RN removed the previous treatment and carried out the treatment change and the Inspector observed that the RN did not utilize an identified treatment as indicated in the resident's orders.

An interview was carried out with RN #119 and the RN stated the identified treatment was unavailable during the change and the RN had followed-up with the Ward Clerk (WC) #124 who was in-charge of ordering the supplies. The RN further acknowledged that the identified treatment had not been applied to resident #012's alteration in skin condition during the change.

An interview was carried out with the DOC and was informed of the above observation carried out for resident #012's treatment. The DOC acknowledged that the identified treatment had not been carried out for resident #012 as part of the treatment order. The DOC stated ADOC #100 found the identified treatment in and identified location of the home and the DOC further indicated staff should have been more vigilant and supplies should have been on the floor as required.

3. The licensee had failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

On an identified date and time Inspector #604 and #723 with the assistance of a Translator #102 conducted a stage one interview with resident #001. The resident indicated they take an identified medication daily for an identified health condition. The resident proceeded to take out an identified medication from an identified location. The resident indicated that their family purchases identified medication and has self-administered the identified medication for the past several months.

Inspector #604 conducted separate interviews with RN #103 and ADOC #104. The RN and ADOC stated as per the home's policy if a resident is to self-administer medications

the resident has to be assessed by the physician and physician's order for self-administering medication is to be obtained. The RN and ADOC reviewed resident #001's physician orders and acknowledged that the resident does not have an order for self-administering of medications in there chart.

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 ensure that;
-on drugs were used by a resident in the home, unless the drug where prescribed for the resident
-drugs had been administered to residents in accordance with the directions for use specified by the prescriber
-no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of

residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

The licensee of a long-term care home shall ensure that the required information was posted for the purposes of subsections (1) and (2) to ensure that copies of the inspection reports from the past two years for the long-term care home was posted.

On an identified date and time Inspector #604 and #723 conducted the initial tour of the home. During the initial tour the Inspectors reviewed the home's posted Ministry of Health and Long Term Care (MOHLTC) reports for the past two years which were placed in a clear folder. The folder was located on the main floor of the home on the left side of reception on the a board titled "Family Communication Board" and the reports where in a clear folder. The following MOHLTC inspection reports where not posted:
-Complaint: report #2017_530673_00009, served June 20, 2017,
-Complaint: report #2017_530673_00008, served June 16, 2017,
-RQI: report #2016_430644_0012, served December 28, 2016,
-RQI: report #2016_302600_0001, served January 4, 2016,

An interview was carried out with the Acting Director of Care (Acting DOC) #100. The Acting DOC was informed of the Inspectors above observations and Acting DOC reviewed the clear folder consisting of the MOHLTC inspection reports and acknowledged that the four reports indicated above where not posted.

Issued on this 18th day of October, 2018

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

Original report signed by the inspector.