

**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
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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
Aug 17, 2021	2021_718535_0014	008349-21, 010932- 21, 011468-21	Critical Incident System

Licensee/Titulaire de permisTendercare Nursing Homes Limited
20 High Park Blvd. Toronto ON M6R 1M7**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**

VERON ASH (535)

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): July 27, 28, 29, 2021.

The following intakes were completed during this inspection:

Log #008349-21 was related to compliance order #001 from inspection #2021_882760_0015 regarding s. 52 (2), with compliance due date July 12, 2021; Log #010932-21 was related to medication incident; and Log #011468-21 was related to abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Director of Care (DOC), Assistant Director of Care and Infection Prevention and Control (ADOC/IPAC) Lead, Environmental Service Manager (ESM), Nurse Practitioner (NP), maintenance worker, registered staff (RN/RPN), personal support workers (PSWs) and Entrance Screeners (ES).

During the course of the inspection, the inspector conducted observations at the screening entrance of the home, resident home areas and staff to resident interactions, reviewed clinical health records, staffing schedule, internal investigation records, follow up compliance plans, compliance audits, supportive and educational resources and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Medication

Pain

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

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

3 WN(s)

3 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 # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 52. (2)	CO #001	2021_882760_0015		535

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. 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 :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a system, the system was complied with.

In accordance with O. Reg. 79/10, s. 114 (3), the licensee was required to ensure that the Medication Administration System included a policy related to medication administration.

Specifically, staff did not comply with the licensee's policy regarding Medication Management RC-16-01-07 dated December 2020, which is part of the licensee's Medication Management program.

A critical incident report was received by the Ministry of Long-Term Care (MLTC) regarding a medication incident.

The resident reported to their substitute decision-maker (SDM) that they were administered more medication tablets instead of the usual amount during a medication pass. The home completed a medication incident and conducted an investigation related to the reported incident.

The RPN verified that they placed the required amount of medication in the residents

medication bin, signed the electronic medication records (eMAR) and forgot to administer the medication to the resident until later that morning. When they discovered the medication in the bin, they administered the right amount to the resident. They denied administering more tablets since they had checked the eMAR and they knew the resident's medications from previous experience.

The Director of Care verified the RPN did not comply with the home's medication administration policy related to administering scheduled medications according to standard administration times and signing for medication prior to administration.

As a result of this non-compliance, the sample size was expanded to include two additional resident's eMAR review on the same home care area. During the same med-pass, two residents' eMARs were signed late and both were administered beyond the scheduled administration time. Therefore, the RPN did not comply with the home's Medication Administration policy regarding the administration of three residents medication.

Source: CIS report, home's investigation notes, interviews with the RPN and DOC. [s. 8. (1) (b)]

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 where the Act or this Regulation require the licensee of a long-term care home to have, institute or otherwise put in place a system, that the system was comply with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #004 was protected from abuse by staff in the home.

For the purposes of the definition of abuse in subsection 2 of the Regulation, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident returned to the home from an external appointment with their substitute decision-maker (SDM). They had sustained an unwitnessed fall the day before and required continued vital signs and neurological monitoring.

The RPN assessed the resident and confirmed that they completed the resident's blood pressure upon their return to the home. During two separate investigation interviews, the resident reported that the RPN was rough when they did their blood pressure which caused an alteration to their skin integrity. They reported the incident to their SDM who informed the Nurse Practitioner (NP).

During the investigation interview, the registered staff first stated they were not aware of the resident's altered skin integrity. They denied causing the issue and suggested that the resident might have returned from their appointment with it. The home's NP reported calling the RPN for support while assessing and treating the resident, and stated that their findings were consistent with the information reported by the resident.

The DOC verified that the RPN was disciplined after the investigation revealed the allegation was founded. The force that was used by the RPN while performing care was in excess of what was appropriate, and the resident sustained an injury.

Sources: CIS report, home's investigation notes, interviews with NP and DOC. [s. 19. (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 the resident was protected from abuse by staff in the home, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature
Specifically failed to comply with the following:**

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

A review of the home's Indoor Temperature and Humidity Logs indicated that resident room air temperature was not being measured and documented.

The home's Maintenance Worker and Environmental Service Manager (ESM) verified that the air temperature was measured and documented in the common areas of the home; however they did not measure and document in writing the air temperature in two resident bedrooms in different parts of the home, as required by the Regulation.

Sources : Indoor Temperature Logs, interview with Maintenance Worker, ESM, and others. [s. 21. (2) 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 the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, to be implemented voluntarily.

Issued on this 19th day of August, 2021

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

Original report signed by the inspector.