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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: January 10, 2023	
Inspection Number: 2022-1157-0002	
Inspection Type: Follow up Complaint Critical Incident System	
Licensee: Tendercare Nursing Homes Limited	
Long Term Care Home and City: Tendercare Living Centre, Scarborough	
Lead Inspector Patricia Mata (571)	**Inspector Digital Signature**
Additional Inspector(s) Rexel Cacayurin (741749)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 1-2, 5-9, 12-14, 2022

The following intake(s) were inspected:
Intake: #00006307 - Follow-up to Compliance Order (CO) #001 from Inspection #2022_1157_0001 related to infection prevention and control.

Two Critical Incident Report (CIR) intakes related to staff-to-resident abuse.
Two CIR intakes related to resident-to-resident abuse.
A CIR intake related to misuse/misappropriation of a resident's money.
A CIR intake related to falls.
A complaint intake regarding resident care, and medication.
A complaint intake related to a complaint about a bed refusal.

The following intake(s) were completed in the Critical Incident System Inspection:
Five CIR intakes related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order (CO) was found to be in compliance:

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Order #001 from Inspection #2022_1157_0001 related to O. Reg. 246/22, s. 102 (2) (b), inspected by Patricia Mata (571).

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

- Infection Prevention and Control
- Skin and Wound Prevention and Management
- Reporting and Complaints
- Prevention of Abuse and Neglect
- Falls Prevention and Management
- Responsive Behaviours
- Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an allegation of abuse of a resident by Registered Practical Nurse (RPN) #119, was immediately reported to the Director.

Rationale and Summary

A critical incident report (CIR) was submitted to the Director for an allegation of abuse of a resident by RPN #119. The incident had been reported to the Social Worker (SW).

An allegation of abuse of a resident by RPN #119 was reported to the SW. The SW completed a complaint form and submitted it to a member of the management team.

The Director of Care (DOC) did not remember when they received the complaint form from the SW. The DOC indicated the SW is a member of a management team. When an allegation of abuse is brought to any member of the management team, they were to report the allegation immediately to the nurse on the floor or an Assistant Director of Care (ADOC), the DOC, or the Executive Director.

By failing to ensure that an allegation of abuse was reported immediately to the Director, the resident was put at risk for further abuse.

Sources: CIR, interviews with the SW, and DOC.
[571]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

The licensee failed to ensure the right to refuse treatment was respected when the substitute decision-maker (SDM) of a resident, acting on the resident's behalf, requested a treatment be discontinued.

Rationale and Summary

On an identified date, the physician order for a resident included a treatment for a specified diagnosis and a referral to a specialist.

The specialist diagnosed the resident with a different condition.The SDM provided Registered Nurse (RN) #123 with a new prescription and emphasized they wanted the current treatment discontinued.

RN #123 informed the SDM they could not accept direction from them related to diagnosis and treatment for the resident.

The Director of Care (DOC) confirmed RN #123 did not call the resident's physician or the specialist to confirm the new diagnosis and treatment or informed them of the SDM's wishes.

By failing to ensure the right to refuse treatment was respected when the resident's SDM, acting on the resident's behalf, requested a specified treatment be discontinued, the licensee negatively impacted the resident/SDM's trust in the health care team and put the resident at risk related to the potential side effects from the specified treatment.

Sources: Record review, interviews with the SDM and DOC.
[571]

WRITTEN NOTIFICATION: Infection Prevention and Control
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: Reg 246/22 s. 102 (2). Infection Prevention and Control (IPAC) Standard Section 9.1 (b)

1) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control were complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022' (IPAC Standard), section 9.1 (b) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Routine Practices shall include hand hygiene, including, but not limited to, at the four moments of hand

hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary

RPN #105 was observed not performing hand hygiene before and after contact with multiple residents while assisting with their medications and feeding.

The IPAC lead stated staff were expected to perform hand hygiene when administering medications and before and after contact with multiple residents. Staff are expected to perform hand hygiene before initial resident and resident environment contact

Failure to perform hand hygiene before and after contact with residents, placed residents at risk of harm from the possible transmission of infectious agents.

Sources: Interviews with IPAC lead and RPN #105, and observations.
[741749]

Non-compliance with: Reg 246/22 s.102 (2). Infection Prevention and Control (IPAC) Standard Section 9.1 (f)

2) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control were complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022' (IPAC Standard), section 9.1 (f) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal, and disposal.

Rationale and Summary

A resident was required additional precautions due to a diagnosis.

A visitor was observed within two meters of the resident without wearing eye protection.

According to the IPAC lead, essential visitors are expected to wear proper PPE including mask, gown, gloves, and eye protection when visiting a resident that is in additional precautions.

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By the visitor not adhering to proper use of PPE, there was risk of transmission of a specified infectious disease to the visitor and possible future transmission to staff and residents during the incubation period.

Sources: IPAC lead interview and observation.
[741749]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40.

Non-compliance with O. Reg. 79/10, s. 36 under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 40 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary

The licensee has failed to ensure staff used safe transferring technique when Personal Support Worker (PSW) #113 transferred a resident from their bed to their assistive device by themselves.

A Critical Incident Report (CIR) was submitted to the Director alleging abuse of a resident by PSW #113. The resident sustained an injury during the transfer.

PSW #113 indicated that they had transferred the resident from their bed to their assistive device by themselves.

The resident's care plan indicated that at the time of the incident, two staff were to provide side by side transfers when transferring the resident.

Failure to utilize safe transferring techniques during care placed the resident at risk for injury.

Sources: CIR, interviews with PSW # 113, the resident's medical records.
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