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
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Original Public Report

Report Issue Date: May 31, 2023	
Inspection Number: 2023-1157-0004	
Inspection Type: Critical Incident System	
Licensee: Tendercare Nursing Homes Limited	
Long Term Care Home and City: Tendercare Living Centre, Scarborough	
Lead Inspector Reethamol Sebastian (741747)	**Inspector Digital Signature** Reethamol Sebastian Digitally signed by Reethamol Sebastian Date: 2023.06.05 12:28:21 -04'00'
Additional Inspector(s) Ana Best (741722) Lucia Kwok (752) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred on-site on the following date(s): May 15, 16, 18, 23, 2023
The inspection occurred off-site on the following date(s): May 17, 19, 2023

The following intake(s) were inspected:
- An intake related to falls prevention and management.
- An intake related to allegation of staff to resident abuse.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain management

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The licensee has failed to comply with communication and pain assessment methods for a resident post-fall.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management program, at a minimum, provides communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, and must be complied with. Specifically, the registered staff did not comply with the licensee's Pain Identification and Management policy when a resident complained of pain post-fall, and their pain was not assessed.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director which indicated that after sustaining a fall, a resident complained of pain in different areas of their body.

The home's Pain Identification and Management policy, indicated that all residents will have a comprehensive pain assessment completed with any new pain, using the home's pain assessment tool.

The resident's clinical records indicated their cognition was impaired. There was no documented records of the home's pain assessment tool post-fall, and the registered staff did not provide pain management interventions for the resident.

The Associate Director of Care (ADOC) acknowledged the resident's pain was not assessed using the home's pain assessment tool, and the staff failed to follow the Pain Management policy when the resident sustained the fall and complained of pain.

By not complying with the Pain Identification and Management policy when the resident complained of pain, potential interventions may have been overlooked, and the resident continued to experience unmanaged pain.

Sources: CIR, resident's clinical records, Pain Identification and Management policy, interviews with registered staff and ADOC.

[741722]

WRITTEN NOTIFICATION: Binding on Licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directive that applies to the long-term care home, specifically, the operational Minister's Directive related to staff masking requirement was complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario, amended March 31, 2023, under section 1.2 Masking, the licensee was required to ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff-to-staff transmission of COVID-19, staff must be physically distanced before removing their medical mask for eating and drinking.

Rationale and Summary

While conducting an observation, inspectors observed a staff not wearing a surgical mask in the Long-Term Care Home (LTCH), with a co-worker in the surrounding.

The staff confirmed they removed the surgical mask to drink water. The staff also indicated they had been educated about proper surgical mask use and acknowledged eating and drinking were only allowed in the designated break area.

The Infection Prevention and Control (IPAC) lead confirmed that staff should wear surgical masks while in the home and they were to only remove their mask in designated break rooms for drinking and eating.

By failing to ensure that the operational Minister's Directive in relation to indoor masking was complied with, the licensee placed residents at risk of exposure to infectious diseases.

Sources: Observation, interviews with staff and IPAC lead.

[741747]

WRITTEN NOTIFICATION: Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 7

The licensee failed to ensure a resident was protected from neglect by a Personal Support Worker (PSW).

Section 7 of the Ontario Regulation 246/22 defines Neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary

A CIR was submitted to the Director, related to alleged physical abuse towards a resident by a PSW.

The resident's clinical records documented that PSW mishandled them by pushing the resident's assistive device forcefully multiple times into a designated area. Witness summary confirmed that, the PSW had to be stopped when they were forcefully pushing the resident and their assistive device into the designated area.

The PSW confirmed that they were trying to fit the resident's assistive device into a tight spot. After the incident, they were disciplined and completed training before returning to work.

The Director of Care (DOC) confirmed that PSW did not treat the resident with dignity and was disciplined.

Failure to ensure that the resident was provided with the safe support from their caregiver, may have negatively impacted resident dignity and wellbeing.

Sources: CIR, resident's clinical records, witness summary, Investigation records, interviews with PSW and DOC.

[741747]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure a post-fall assessment was conducted using a clinically appropriate assessment instrument.

Rationale and Summary

A CIR was submitted to the Director related to a resident's fall, that resulted in an injury and transfer to a medical facility.

The home's Fall Prevention and Management policy required that for post-fall management, the registered staff member would complete a post-fall assessment tool.

The resident's clinical records revealed that, the registered staff on shift did not complete a post-fall assessment tool when they complained of pain in different areas of their body. Furthermore, the progress note related to the fall was created by a registered staff who did not respond to the resident's fall.

The registered staff and the DOC confirmed upon their own review of resident's clinical records, that the registered staff on shift failed to complete a post-fall assessment using the LTCH's post- fall assessment tool.

By failing to ensure a post-fall assessment tool was completed, the resident was at risk for unidentified injuries related to the fall.

Sources: CIR, resident's clinical records, home's Fall Prevention and Management policy, interviews with registered staff and DOC.

[741722]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that when the resident exhibited altered skin integrity, they received a skin and wound assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A resident had experienced a fall that led to a significant change in health condition and required medical treatment.

The resident's clinical records indicated they returned to the LTCH with altered skin integrity, and the registered staff failed to complete a skin and wound assessment.

A registered staff indicated that upon readmission, registered staff was to complete the required skin and wound assessment and document into Point Click Care (PCC).

Failure to completing a skin assessment for the resident, might have impacted staff from monitoring and managing the resident's altered skin integrity conditions.

Sources: CIR, resident's clinical records, interviews with registered staff.

[741722]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that the resident was reassessed at least weekly by a member of the nursing staff when they exhibited altered skin integrity.

Rationale and Summary

A resident had experienced a fall that led to a significant change in health condition and required medical treatment.

The resident's clinical records revealed that weekly skin assessments were not completed for the resident's altered skin integrity areas.

A registered staff confirmed the required weekly skin assessments were not completed for the resident's impaired skin areas during the healing process period.

Failure to complete a weekly skin and wound assessment might have prevented the staff from monitoring the resident's altered skin integrity areas, posing a risk for prolonged skin healing.

Sources: CIR, resident's clinical records, interviews with registered staff.

[741722]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
1) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard, section 6.1

The licensee failed to ensure that the IPAC standard issued by the Director related to personal protective equipment (PPE) was followed.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 6.1, the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for routine practices and additional precautions.

Rationale and Summary

During the initial tour, it was observed that two rooms were under isolation precautions. A signage posted on the door indicated the required PPE included long sleeved gown, gloves, masks, and eye protection.

One PPE caddie did not contain eye protection and masks. The other PPE caddie did not contain eye protection.

A registered staff stated all staff in the unit were responsible for ensuring PPE caddies were restocked and this was not followed at the time of the observation.

The IPAC lead confirmed the surgical mask and eye protection should be in the PPE caddies.

Failing to ensure PPE is available and accessible to staff and visitors posed potential risk for spreading infectious disease.

Sources: Observations, interviews with IPAC lead and registered staff.

[741747]

2) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 10.1

The licensee failed to ensure that the IPAC standard issued by the Director related to hand hygiene was followed.

In accordance with Additional Requirement 10.1 under the IPAC Standard, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

During the initial tour it was observed that, the hand sanitizer bottle placed on top of the PPE caddie in front of a room, had an expiry date of July 2022. This bottle was the only accessible ABHR near the entrance of that room.

The IPAC lead confirmed that expired ABHR should not have been in use in the home. The IPAC lead also indicated that the direction from the previous IPAC lead, was to utilize the expired hand sanitizer and acknowledged there was no confirmation of the source providing this direction.

Due to the home using expired hand hygiene agents, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents.

Sources: Observations, interviews with IPAC lead and registered staff.

[741747]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. v.

The licensee failed to report to the Director the outcome of the staff member involved in an investigation submitted to the Director.

Rationale and Summary

A CIR was submitted to the Director, related to alleged staff to resident physical abuse. As per the CIR, an internal investigation was completed and PSW was disciplined immediately and had to complete training on Resident's Bill of Right, Abuse and Neglect before returning to work.

The home's Investigation Checklist policy indicated that the home has to create an investigation package which organizes the investigation materials and findings in a user-friendly manner and retain it in a safe place.

The DOC confirmed that PSW did not treat the resident with dignity, and they were disciplined. The DOC also indicated that an investigation was completed by the former DOC, however upon request by the inspector, the home was unable to produce the investigation report.

There was no risk identified to the resident, when the licensee failed to ensure that the investigation report was kept at the LTCH.

Sources: CIR, home's Investigation Checklist policy, interviews with PSW and DOC.

[741747]

WRITTEN NOTIFICATION: Records, where kept

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 281 (1) 1.

The licensee failed to ensure that the current staff member's disciplinary action record was kept at the LTCH.

Rationale and Summary

A CIR was submitted to the Director, related to alleged PSW to resident physical abuse. As per the CIR, an internal investigation was completed and PSW was disciplined. PSW had to complete training before return to work.

PSW confirmed that after the incident they were disciplined and completed training.

The DOC confirmed that PSW did not treat the resident with dignity. The DOC also indicated that an investigation was completed by the former DOC, and the PSW was disciplined. However, upon request by the inspector the home was unable to produce the disciplinary action records.

There was low risk to the resident when the licensee failed to ensure that disciplinary action records of PSW were kept at the LTCH.

Sources: CIR, interviews with PSW and DOC.

[741747]