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: July 12, 2024
Inspection Number: 2024-1157-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Tendercare Nursing Homes Limited
Long Term Care Home and City: Tendercare Living Centre, Scarborough

Lead Inspector	**Inspector Digital Signature**
Asal Fouladgar (751)	Asal Fouladgar Digitally signed by Asal Fouladgar Date: 2024.07.17 15:36:14 -04'00'

Additional Inspector(s)
Julie Dunn (706026)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24-28, July 2-3, 2024.

The following intake(s) were inspected:

- An intake related to Proactive Compliance Inspection (PCI)

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement

Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Air temperature

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

During this Proactive Compliance Inspection, air temperature logs were provided to the inspector for a specific time period.

The air temperatures were recorded hourly in sixteen different resident areas of the home. There were several days with air temperatures recorded below 22 degrees Celsius, at times as low as 18 degrees Celsius, for hours at a time. The air temperature recorded for the recreation room was consistently below 22 degrees Celsius for several days at a time.

During an observation in this inspection, the residents who were gathered in the recreation room for an activity were wearing sweaters, jackets, vests and blankets. On the second floor, Personal Support Worker (PSW) #110 was wearing a cardigan sweater over their uniform and indicated that they found it to be cool in the home.

The Executive Director (ED) acknowledged that the air temperatures in some areas had been below 22 degrees Celsius. The ED also confirmed that numbered rooms noted on the air temperature logs were resident rooms and the recreation room was the room on the main level used for resident activities. The ED indicated it was difficult to regulate temperatures in a building that size and noted that the home purchased blanket warmers and towel warmers for each resident home area, so staff could provide a warm blanket if a resident was cold.

Failing to ensure the home was maintained at a minimum temperature of 22 degrees Celsius put residents at risk of discomfort.

Sources: The home's air temperature logs, interviews with the ED and PSW #110, observations.
[706026]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.

The licensee has failed to ensure that every designated lead in the home was a member of their continuous quality improvement (CQI) committee.

Summary and Rationale

A review of the home's last meeting minutes for the CQI committee, indicated multiple designated leads were not in attendance.

The ED acknowledged that there was no further documentation to indicate the members invited for the home's last CQI committee meeting and confirmed that every designated lead of the home including restorative care, recreation and social activities, volunteers, and training and orientation leads were not part of the CQI committee.

By failing to include every designated lead of the home on the CQI committee, the opportunity for input related to such areas relating to residents was lost.

Sources: CQI meeting minutes, and an interview with the ED.
[751]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that the home published a report on their CQI initiative on its website.

Summary and Rationale

A review of the home's website and an interview with the ED both confirmed the home's website was not revised to include their CQI initiative reports.

By failing to post the CQI initiative report on the website, the opportunity to share information to outside stakeholders was lost.

Sources: Home's website, and an interview with the ED.

[751]

WRITTEN NOTIFICATION: Continuous quality improvement

initiative report

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 1.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.

The licensee has failed to ensure the home's CQI initiative report included the name and position of the designated lead for the CQI initiative.

Summary and Rationale

The home's ED and Director of Care (DOC) both indicated that the home's DOC was the lead for the CQI initiative committee. A review of the home's CQI report and an interview with the ED both confirmed the home's CQI report did not include the name of the home's DOC as the lead for the CQI committee.

By failing to include the name of the DOC as the lead in the CQI initiative report, the opportunity to share information to residents and families was lost.

Sources: Home's CQI initiative report, interviews with the ED and DOC.
[751]