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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 18, 2017	2017_420643_0012	008386-16, 023456-16, 027169-16, 027215-16, 029253-16, 003855-17, 006650-17, 007408-17, 008622-17, 011330-17, 011331-17, 011754-17	Critical Incident System

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

ADAM DICKEY (643), ANGIE KING (644), BABITHA SHANMUGANANDAPALA (673), SUSAN SEMEREDY (501)

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): June 9, 12-16, 19-23, and 26, 2017.

The following Critical Incident intakes were inspected during this inspection:
- Log #011330-17, #011331-17, #011754-17, #023456-16, #003855-17, #008622-17, #007408-17 and #008386-16 related to alleged resident abuse;
- Log #027169-16 related to responsive behaviours;
- Log #006650-17 related to unsafe transferring techniques;
- Log #029253-16 related to elopement of a resident; and
- Log #027215-16 related to falls prevention and management.

Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10, C.8, s. 98, identified in concurrent inspection #2017_626501_0014 (Log #003149-16) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Nurse in-Charge (RNIC), Registered Practical Nurses (RPN), Registered Physiotherapsts (PT), RAI Coordinator, Environmental Services Manager (ESM), Social Worker (SW), Personal Support Workers (PSW), Activation Assistants (AA), Student Personal Support Worker (S-PSW), residents, Substitute Decision Makers (SDM), and family members.

During the course of the inspection the inspectors observed the provision of care, resident to resident interactions, staff to resident interactions, reviewed medical records, personnel files, education records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **13 WN(s)**
- **7 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #010.

A Critical Incident System report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to a fall incident involving resident #010 who had fallen from an identified piece of care equipment to the floor resulting in transfer to hospital, where he/she was diagnosed with an identified injury.

Review of resident #010's health records revealed that he/she was assessed to have impaired cognition. Resident #010 had an identified responsive behaviour per an assessment from an identified date.

Review of resident #010's progress notes revealed that at an identified time and date, RN #122 received a call from RN #149 on an identified unit that resident #010 had fallen. The progress notes further indicated that resident #010 was found sitting on the floor next to the above mentioned identified care equipment. Initial assessment was completed and resident #010 was able to move his/her extremities but refused to walk. Resident #010 was later observed to be unable to stand and grimacing in pain and was unable to bear weight. Resident #010 was sent to hospital for assessment.

In an interview, RN #122 stated that resident #010 exhibited an identified responsive behaviour. RN #122 further stated that resident #010 was independent with locomotion, and did not have a history of frequent falls. RN #122 stated that he/she had been called to above mentioned identified unit and found resident #010 to be sitting on the floor, able to move his/her extremeties at the time and was assisted by a PSW to transfer resident #010. RN #122 stated that he/she was unaware why the above mentioned identified care equipment was located in an identified common area, and that this equipment is not for resident use.

In an interview, RN #149 stated that at an identified time he/she was alerted that resident

#010 had fallen. RN #149 further stated that he/she was doing documentation at the time and had not noticed resident #010 sitting on the identified care equipment. RN #149 stated that he/she was not aware why the identified care equipment was in the hallway, and that this care equipment is not safe for resident use and should only be kept in a specified location for staff use.

In an interview, RPN #150 stated that resident #010 exhibited responsive behaviours and that it was normal to see resident #010 on the identified unit. RPN #150 further stated that he/she was at the nursing station doing documentation near shift change and did not see resident #010 fall. RPN #150 stated that he/she was not sure why the identified care equipment had been left in the common area, and that this care equipment is not safe for residents who could easily lose balance and fall from them.

In an interview, Physiotherapist (PT) #152 stated that the identified care equipment is not stable for residents to use. PT #152 stated that this care equipment is not safe for residents to use and staff should keep the care equipment where confused residents cannot access them.

Observations by the inspector revealed a piece of the above mentioned identified care equipment in a common area of the unit. There were four residents in the area at the time, three were wheelchair bound, the fourth was ambulatory using a walker. At the time of observation there were no staff members present in the area. In an interview, RPN #157 stated that the above mentioned care equipment was not for resident use and should be kept in a specified location for staff use. RPN #157 further stated that staff are instructed to not allow residents to use the identified care equipment and remind staff that they are a safety issue.

In an interview, the DOC stated that the identified care equipment should be stored in an identified location, where residents are unable to access them. The DOC acknowledged that as resident #010 had been able to access the identified care equipment in a common area and that the licensee had failed to ensure the home was a safe and secure environment for resident #010.

The severity of this noncompliance was identified as actual harm to resident #010, the severity was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and voluntary plan of correction (VPC) were issued on January 7, 2015, under inspection report #2014_249555_0029 for noncompliance with LTCHA, 2007 S.O. 2007, c.8, s. 5. Due to the severity of actual harm and previous

noncompliance with VPC a compliance order is warranted. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #012 as specified in the plan.

Review of a CIR submitted to the MOHLTC, revealed that resident #012 was treated roughly by a PSW. Resident #012's SDM reported that when the resident rang the call bell for assistance, a PSW came into his/her room, spoke loudly and handled him/her roughly. The resident sustained an injury.

Review of the plan of care from the time of the incident, revealed resident #012 required the assistance of two staff members for assistance with identified care tasks. Review of an assessment from an identified date, revealed resident #012 had evidence of injury to an identified area of his/her body. Review of progress notes revealed that on an identified date, x-ray results indicated resident #012 sustained a specified injury.

In an interview, PSW #116 indicated he/she provided care alone to resident #012 at an

identified date and time, and had not checked the plan of care. PSW #116 was not aware that resident #012 required two staff to assist with the identified care tasks.

In an interview, RN #156 stated that resident #012 required the assistance of two staff for identified care tasks. In an interview, the DOC acknowledged that the home failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #016 as specified in the plan.

On an identified date, the MOHLTC received a CIR related to an allegation of staff to resident abuse. Review of the CIR revealed that resident #016 alleged that PSW #158 had been rough with the resident while assisting him/her with care.

Record review of resident #016's interdisciplinary team care conference, noted resident #016 exhibited identified responsive behaviours.

Review of the MDS quarterly review assessment from an identified date, revealed that resident #016 had specified disease diagnoses. The MDS assessment further revealed that resident #016 had limited range of motion in identified areas of his/her body.

Review of resident #016's written plan of care noted that resident #016 was impaired related to physical limitation. One of the interventions included two staff to provide extensive to total assistance with identified care tasks.

Review of resident #016's progress notes from an identified date, by RPN #159, revealed that resident #016 stated, PSW #158 had treated him/her roughly and had not provided proper care assistance.

In an interview, resident #016 stated that he/she has limited range of motion in identified areas of his/her body. Resident #016 further stated that one PSW typically assists him/her with the identified care task, and that the care task feels rough.

In an interview, PSW #158 stated that on an identified date, PSW #160 helped him/her transfer resident #016; however, PSW #160 did not stay to assist with resident #016's care, and that he/she completed the identified care tasks on his/her own. PSW #158 further stated that he/she had not reviewed resident #016's plan of care prior to providing

care to him/her that day.

In an interview, PSW #160 stated that he/she had assisted resident #016 with a specified care task, but did not provide assistance with the above mentioned identified care tasks.

In an interview, RPN #159 stated that resident #016 exhibits identified responsive behaviours, and that two staff are to provide assistance with the identified care tasks, as per the plan of care.

In an interview, ADOC #100 acknowledged that as PSW #158 completed the identified care tasks for resident #016 without the assistance of another staff member that care was not provided to resident #016 as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #017 as specified in the plan.

MOHLTC received a CIR on an identified date, related to alleged rough treatment. Resident #017 reported to Activation Aide (AA) #151 that PSW #154 was rough during care and hit the resident with an identified object.

Review of resident #017's health records revealed he/she hada history of identified responsive behaviours. Review of resident #017's MDS assessment from an identified date, revealed that he/she exhibited specified responsive behaviours.

In interviews, PSWs #153, #154, RPN #119, ADOC #164 and ADOC #100 stated that the plan of care and kardex were available to all direct care staff on a mobile Point of Care (POC) tablet for each staff at the nursing station.

Review of resident #017's written plan of care revealed identified strategies to manage resident #017 behaviours. It was also documented that the resident was known to exhibit identified responsive behaviours.

In an interview, PSW #154 stated that he/she was not aware of the interventions detailed in resident #017’s plan of care for providing personal care to the resident. PSW #154 further stated that he/she did not review the plan of care or the kardex that was available on the mobile POC tablet.

In interviews, (ADOC) #100 and ADOC #164 stated that the behaviour management

interventions were documented in resident #017's plan of care and that PSW #154 did not review and implement the strategies prior to care being provided.

The severity of this noncompliance was identified as actual harm to resident #012, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and voluntary plan of correction (VPC) were issued on February 8, 2016, under inspection report #2016_302600_0001 for noncompliance with LTCHA, 2007 S.O. 2007, c.8, s. 6. (7). Due to the severity of actual harm and previous noncompliance with VPC a compliance order is warranted. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Review of a CIR submitted to the MOHLTC revealed RPN #132 reported to inspector #501 that PSW #116 has left resident #002 in an identified piece of care equipment unattended with the door of his/her room closed.

In interviews, PSW #116 and RPN #132 stated resident #002 was left in the identified care equipment as a method of assisting the resident. According to PSW #116, he/she believed that it was a better method to assist the resident and was aware that his/her method was not included in the plan of care.

Review of resident #002's most recent plan of care revealed the resident requires total assistance with an identified care task Two staff are required for transfers to and from the bed using an identified method when staff assisted resident #002 with the identified care task.

In interviews, PSW #116, #106, #107, #127, RPN #130, #132 and RN #131 stated that staff were aware of resident #002's identified responsive behaviours. Review of a progress note revealed resident #002 continued to exhibit identified responsive behaviours.

In an interview, the DOC stated he/she was disappointed that registered staff had done little to assess resident #002 and was alarmed that a PSW took it into his/her own hands to trial a method that diminished the resident's dignity. Interview with RN #121 revealed that he/she was aware that PSWs had concerns with his her identified responsive behaviours. RN #121 stated that PSW #116 had this concern and gave the PSW

identified instructions for caring for the resident. Interviews with PSW #116 and RPN #132 indicated that from now on they will discuss their observations and concerns and ensure residents are assessed when a resident's current plan of care is not effective.

In an interview, the DOC stated that registered staff should have reassessed resident #002 and the situation and could have measures to reassess the resident. The DOC acknowledged that resident #002 was not reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 protect resident #002 from abuse.

Review of a CIR revealed resident #002 and his/her SDM reported to the inspector that the resident's regular night PSW screamed at him/her while providing care three to four days ago.

While interviewing resident #002 and his/her SDM regarding a complaint and CIR, resident #002 expressed to the inspector a week ago that someone had screamed at him/her when providing care. The inspector informed the home and a CIR was submitted.

Review of a hand written note by resident #002 which had been provided to the home by the SDM revealed the resident identified PSW #116 as disliking him/her, and disliking assisting resident #002 with identified care tasks because of an identified responsive

behaviour.

Record review revealed resident #002 was admitted to the home on an identified date, with an identified diagnosis. Review of resident #002's assessment from an identified date indicated that he/she was assessed to have impaired cognition. Review of resident #002's most recent plan of care revealed the resident requires total assistance with an identified care task. Two staff are required for transfers to and from the bed with a specified piece of care equipment when staff assist resident #002 with the identified care task.

In an interview, PSW #116 stated that resident #002 exhibits identified behaviours. PSW #116 stated he/she asks resident #002 "why you do this?" According to PSW #116, he/she reports to the RPN what has occurred who then comes to check. In an interview RPN #132 stated that PSW #116 reports to him/her when resident #002 exhibits the above mentioned behaviour and he/she will come to assess the situation. According to the RPN, this conversation occurs in an identified unit area that may be overheard by resident #002.

Review of the home's investigation notes revealed PSW #116 admitted to speaking about resident #002 in a public area and would refrain from doing so in the future. Review of a discipline letter to PSW #116 revealed that he/she was being suspended for five days due to resident #002 overhearing him/her saying something about him/her which made him/her feel very humiliated.

Interview with the DOC acknowledged that the home failed to protect resident #002 from emotional abuse. [s. 19. (1)]

2. The home has failed to protect resident #012 from abuse.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that resident #012 was treated roughly by a PSW on an identified date. Resident #012's SDM reported that at an identified time, the resident rang the call bell for assistance. A PSW, who was not the resident's primary care giver, came into the room, spoke loudly and handled the resident roughly. According to the resident, the PSW turned off the call bell, roughly removed the bed table and as the resident assisted by turning onto his/her side, the PSW pushed him/her over further. This was done so roughly that it caused the resident to strike a piece of identified care equipment which caused an injury. The resident complained of pain and x-ray revealed an injury. The home's investigation

confirmed that PSW #116 answered the call bell and provided resident #012 care on the above mentioned date.

Record review revealed an assessment completed on an identified date, revealed the resident was assessed to have impaired cognition. Review of the plan of care from the time of the incident, revealed resident #012 required the assistance of two staff members for assistance with identified care tasks. Review of an assessment from an identified date, revealed resident #012 had evidence of injury to an identified area of his/her body. Review of progress notes revealed that on an identified date, x-ray results indicated resident #012 sustained an injury.

During an interview, resident #012 stated that he/she remembered the incident and described and gestured that the PSW was rough with him/her. Resident #012 said he/she struck the identified care equipment causing pain. In an interview, resident #012's family member who reported the incident to RN #156, stated resident #012 told him/her that a PSW, who was not the resident's regular PSW, was rough and yelling. According to the family member, resident #012 stated the PSW pushed him/her so hard that he/she struck the identified care equipment. The inspector observed that the identified care equipment was in a position that would account for such an injury. According to the family member, the resident complained of pain.

In an interview, PSW #116 admitted to providing care alone to resident #012 at the specified date and time, but denied handling the resident in a rough manner. PSW #116 stated he/she was disciplined for this but has never intentionally hurt anyone.

In an interview, RN #132 stated that resident #012's family member reported rough handling on an identified date, which had occurred the day prior. According to the RN, he/she recalled that resident #012 had evidence of injury and was in some discomfort. The RN also indicated resident #012 required the assistance of two people for an identified care task.

In an interview, the DOC acknowledged the home failed to protect resident #012 from abuse. [s. 19. (1)]

3. The licensee has failed to ensure that residents are protected from abuse by anyone.

Review of a CIR submitted to the MOHLTC on an identified date, revealed an altercation between resident #009 and resident #010. Resident #010 was sent to hospital for

treatment of his/her injuries.

Review of resident #009's health records revealed resident #009 was assessed to have cognitive impairment. Resident #009 had limited range of motion in one extremity, and used an identified device for independent ambulation with supervision.

Review of resident #009's progress notes revealed that at an identified date and time, resident #009 exited an identified unit area and exhibited an identified responsive behaviour toward resident #010 resulting in injury. Progress notes revealed resident #009 exhibited an identified responsive behaviour towards a co-resident which had occurred thirteen days prior to the incident involving resident #010.

Review of resident #010's health records revealed he/she was assessed to have impaired cognition. Resident #010 had an identified responsive behaviour per the MDS assessment.

In an interview, RN #122 stated that he/she was called to an identified unit when the incident occurred. He/she stated that resident #010 had evidence of injury. RN #122 further stated that resident #010 was sent to hospital for treatment. RN #122 stated that resident #010 had exhibited identified responsive behaviours.

In an interview, RPN #144 stated that resident #010 would sit in an identified area of an identified unit. RPN #144 further stated that resident #009 demonstrated an identified responsive behaviour toward resident #010 as resident #009 believed that resident #010 was sitting in his/her chair. RPN #144 stated that resident #009 had a history of demonstrating identified responsive behaviours, but did not recall any other incidents of identified responsive behaviours toward co-residents.

In an interview, RN #148 stated that resident #009 had a disagreement with someone, and had walked out of the identified unit area when he/she exhibited the identified responsive behaviour toward resident #010. RN #148 stated that resident #009 was not known to demonstrate the identified responsive behaviour and that this behaviour was out of the ordinary for resident #009. RN #148 further stated that resident #009's device was taken away and placed in the medication room. RN #148 stated that if resident #009 was known to be aggressive he/she should not have been allowed to use the device as an aid.

In an interview, the DOC acknowledged that in this case, resident #010 had not been

protected from abuse by resident #009.

The severity of this noncompliance was identified as actual harm to residents #012 and #010, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification and compliance order were issued January 7, 2015, under inspection report #2014_249555_0029 for noncompliance with LTCHA, 2007 S.O. 2007, c.8, s. 19. Due to the severity of actual harm and prior noncompliance with a compliance order a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote residents right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Review of a CIR submitted to the MOHLTC on an identified date, revealed RPN #132 reported to the inspector that PSW #116 has left resident #002 in ain an undignified manner and unattended with the door of his/her room closed.

During an interview with RPN #132, RPN #132 revealed that he/she has found resident #002 left alone in an undignified manner by PSW #116. According to RPN #132, this happened twice and he/she had reported this to RN #121 and the DOC. Further interview with RPN #132 revealed the first time he/she noticed this was a couple of weeks ago

when he/she entered resident #002's room to administer a co-resident's medication. RPN #132 stated that the door was closed and when he/she entered the room he/she observed resident #002 in the undignified manner and the resident was not clothed. RPN #132 stated he/she relieved the resident from the undignified position and then PSW #116 entered the room. PSW #116 told RPN #132 that he/she had left to get something and explained that he/she wanted to assist the resident in this manner. RPN #132 further stated that the second time he/she observed this, PSW #116 was in the room attending to another resident. RPN #132 noted that resident #002's curtain was only half closed.

In an interview, PSW #116 stated that he/she would leave resident #002 in the above mentioned care equipment to make a care task easier for the resident. According to PSW #116, he/she never left resident #002 alone in the equipment but would sit in a chair next to him/her. PSW #116 stated resident #002 was only in the undignified state for five to ten minutes and he/she had used this technique three times. According to PSW #116, resident #002 gave his/her permission for him/her to do this but was aware that this was not part of his/her plan of care.

Review of resident #002's most recent plan of care revealed the resident required total assistance for an identified care task. Two staff were required for transferring to and from the bed with an identified device when staff assisted resident #002 with the above mentioned identified care task.

In an interview, resident #002 stated that an identified device was used to transfer him/her and PSW #116 left him/her in the equipment for 15-30 minutes and he/she has been assisted with an identified care task. Resident #002 stated he/she was uncomfortable in the equipment but does not feel unsafe due to personal faith. The resident further stated that when he/she is left in this manner he/she loses his/her dignity.

In an interview, the DOC stated he/she had met with resident #002 and his/her SDM and it was revealed that resident #002 would prefer not to be assisted in this manner. The DOC acknowledged that this technique did not fully respect and promote resident #002's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity. [s. 3. (1) 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 with ensuring that the residents right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the elevators are equipped to restrict access to areas that are not to be accessed by residents.

On an identified date, the MOHLTC received a CIR related to a missing resident. Review of the CIR revealed that resident #013 eloped from the home and was missing for greater than three hours. The resident was found unharmed and returned to the home by two police officers.

Observations by the inspector at an identified date and time, revealed that the main elevators did not restrict access to the basement. The basement contained an unsupervised garage area/room with a door which was left open, leading to an unsecured parking lot. The doors leading to this area had a posted sign stating "residents/visitors not permitted past this door". The basement also had access to other unsupervised areas including the laundry room, and rooms with exposed electrical wires.

Environmental Service Manager (ESM) #134 was shown this finding, and he/she stated that it was a malfunction with the elevator. ESM #134 further stated that having access to these locations through the elevators was not safe for residents.

In an interview, ADOC #100 confirmed that residents having access to unsupervised areas in the basement, with doors open to an unsecured parking lot was not safe.

On an identified date, at two identified times, the inspector observed that the main elevators did not restrict access to the retirement floors/units. The inspector was able to access floors which were designated as retirement units, where there was no staff observed at the front desk. Further observation of the floor revealed an unlocked medication room with an open medication cart, with no staff in the vicinity. The medication cart contained identified medications and administration devices. RN #163 who was working on the unit, stated that the medication room doors are usually kept closed, and he/she had stepped away because he/she was administering medications.

In an interview, ADOC #100 stated that the retirement floors are considered restricted areas for residents of the long term care home; however, the elevators have access to these floors. He/she further stated that residents have wandered up to these floors in the past, and staff on the retirement floor will call the long term care home to bring the residents back to their appropriate units. [s. 10. (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 with ensuring that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy number RC-01-02 last updated April 2016, revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/ designate/ reporting manager or the most senior Supervisor on shift at that time. The policy further states that in Ontario, anyone who suspects or witnesses abuse or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long-Term Care (MOHLTC) Director through the Action Line.

Review of a CIR submitted to the MOHLTC revealed that on an identified date, a family member of resident #003 reported to RN #124 that PSW #123 was rough with resident #003. A suspected injury was found on an identified area of resident #003's body. The incident was first reported to the MOHLTC the following day at an identified time.

In an interview, RN #136 stated that he/she had received the report from RN #124. RN #136 stated that RN #124 reported the family's allegation that someone had srtuck resident #003 to RN #136 shift change and was busy doing report for the shift. RN #136 further stated that he/she had then passed the information on to RN #137 who was the RN-in charge for the oncoming shift. RN #136 stated that she did not call the DOC or action line to report the allegation.

In an interview, RN #137 stated that he/he did not receive the report from RN #136. RN #137 further stated that he/she would have reported the allegation to the DOC as well as call the action line as the RN-in charge of the facility on evening shift.

In an interview, the DOC stated that he/she became aware of the allegation of abuse of resident #003 on the morning following the allegation, when reviewing report. The DOC stated that it was the expectation of the home that all staff are to follow the Long-Term Care Homes Act regarding immediate reporting. The DOC further stated that it was the practice of the home for staff to report to the ADOC, DOC, or administrator, or if an incident occurred in the evening report to the ADOC. The DOC stated that if the ADOCs, DOC and administrator are all off-site staff should call the after-hours line and call the DOC and let him/her know about it. The DOC acknowledged that the alleged abuse of resident #003 was not immediately reported to the director, and that staff of the home failed to comply with the home's written policy on zero tolerance of abuse and neglect. [s. 20. (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 with ensuring that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A CIR was submitted to the MOHLTC related to a resident altercation which occurred on an identified date. According to the CIR resident #004 was noted to be agitated beginning at an identified time, exhibiting identified responsive behaviours. Approximately one hour later, resident #004's behaviours were escalating and continued to exhibit identified responsive behaviours. Resident #004 then exhibited identified responsive behaviours toward co-residents, striking resident #005 and #006.

Review of resident #004's health records revealed that he/she had been assessed as cognitively impaired. The MDS assessment indicated that resident #004 exhibited identified responsive behaviours.The MDS assessment indicated that resident #004's behavioural symptoms had deteriorated since the last quarterly assessment.

Review of resident #004's progress notes revealed he/she had been exhibiting identified responsive behaviours at an identified time. Approximately two hours later hours it was reported to RPN # 165 by RN #169 that resident #004 had been exhibiting identified responsive behaviours. Approximately twenty minutes later, resident #004 went to the nurse's station and exhibited identified responsive behaviours. Resident #004 was then observed moving towards his/her resident room passing by resident #006, when resident #004 exhibited an identified responsive behaviour toward resident #006. Resident #004

then was observed moving back toward where resident #005 was sitting, when resident #004 exhibited an identified responsive behaviour toward resident #005.

Review of resident #004's written plan of care from an identified date, revealed that he/she exhibited identified responsive behaviours. Resident #004 had worsened mood and behaviour over the past quarter which was not easily altered. Staff were instructed to separate resident #004 from other residents right away when he/she was exhibiting identified responsive behaviours, as well as to provide distraction with identified activities.

In an interview, RPN #119 who was a member of the BSO team stated that resident #004's identified responsive behaviours were frequently exhibited at identified times of the day. RPN #119 further stated that resident #004 had exhibited identified responsive behaviours towards both staff and residents, including one incident in which he/she had exhibited identified responsive behaviours toward co-residents on his/her unit. RPN #119 stated that other residents would need to be removed from the area if resident #004 was exhibiting identified responsive behaviours to prevent altercations and ensure the safety of the other residents.

In an interview, RPN # 165 stated that interventions in place to manage resident #004's behaviours were to talk to him/her, redirection and PRN medication administration. He/she further stated that staff were instructed to get all residents away from resident #004 at once when he/she exhibits identified responsive behaviours. RPN #165 stated that resident #004 would be monitored and other residents would not be allowed to come near resident #004.

In an interview, RN #169 stated that resident #004 had exhibited identified responsive behaviours and that other families were concerned. He/she stated that an intervention that had been identified to manage resident #004's behaviours was for staff to move the other residents out of the area if resident #004 exhibited identified responsive behaviours and let resident #004 move about on the unit. RN #169 stated that staff would try to talk to resident #004 and calm him/her, and call the family but these interventions did not always work and after a while he/she would calm on his/her own. RN #169 stated that on the evening of the incident, as resident #004 had been noted to be exhibiting identified responsive behaviours, and these behaviours were escalating that staff should have implemented the intervention identified and that the other residents should have been removed from the area sooner in order to prevent altercations or potentially harmful interactions with resident #004.

In an interview, the ADOC stated that resident #004 can exhibit identified responsive behaviours at an identified time of day, and acknowledged that he/she had been exhibiting the identified responsive behaviours for a period of over one hour prior to the incident involving residents #005 and #006. The ADOC acknowledged that the staff could have moved the other residents from the area sooner and had failed to implement the interventions identified to minimize the risk of altercations and potentially harmful interactions with resident #004. [s. 54. (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 with ensuring that steps are taken to minimize altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring the staff member.

Review of personnel files revealed PSW #146 started working at the home on an identified date and his/her criminal reference check was not completed until thirty-four days after the hire date.

Interview with the ED acknowledged PSW #146 was hired prior to having a criminal reference check conducted. [s. 75. (2)]

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 with ensuring that the screening measures conducted before hiring staff and accepting volunteers includes criminal reference checks, unless the person being screened is under 18 years of age, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified any any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that resident #012 was treated roughly by a PSW on an identified date. Resident #012's SDM reported that at an identified time, the resident rang the call bell for assistance. A PSW came into his/her room, spoke loudly and handled him/her roughly. The resident sustained an identified injury and the PSW was disciplined for physical abuse.

Review of the CIR and the resident's progress notes did not reveal that the police had been notified of this incident. Interview with the DOC acknowledged that this incident may constitute a criminal offence and the police were not contacted.

2. The following evidence related to resident #002 was found under inspection report 2017_626501_0014.

The license has failed to ensure that the appropriate police force was immediately

notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Review of a complaint from resident #002's family and a CIR revealed an allegation of staff to resident abuse was reported to the home on an identified date. According to the CIR, resident #002 alleged he/she had been experiencing abuse by his/her regular night shift PSW #106.

Review of the home's investigation notes revealed that a meeting took place seventeen days following the allegations being reported to the home, regarding the alleged abuse with the staff and family of resident #002. The staff members all denied striking resident #002. However, the family was not convinced. The home told the family they could not substantiate their complaint and informed resident #002's SDM that he/she had the right to call the police if he/she felt strongly that his/her spouse had been abused.

In an interview, the ED acknowledged that the above mentioned allegation was a type of alleged abuse that he/she would consider a criminal offence. The ED stated he/she did not feel it was warranted to contact the police because the home was in conversation with the family. The ED further indicated that he/she thought the home should complete their investigation first and he/she did not feel there was any reason or evidence to do so at that time. [s. 98.]

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 with ensuring that the appropriate police force is immediately notified of any alleged, suspected or witnessed abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

s. 215. (3) The criminal reference check must include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. O. Reg. 79/10, s. 215 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the criminal reference check must be conducted within six months before the staff member is hired.

According to the LTCH Act 2007, subsection 75(2), a criminal reference check is required before a licensee hires a staff member.

Review of personnel files revealed RN #131 was hired on an identified date, and his/her criminal reference check was conducted eight months prior to the date of hire.

Interview with ADOC #100 acknowledged that RN #131's criminal reference check was conducted more than six months prior to the staff member being hired. [s. 215. (2)]

2. The licensee has failed to ensure that the criminal reference check includes a vulnerable sector screen to determine the person's ability to be a staff member in a long-term care home and to protect resident from abuse and neglect.

Review of personnel files revealed RPN #147's criminal reference check did not include a vulnerable sector screening.

Interview with the ED could not confirm that the criminal reference check conducted for RPN #147 included a vulnerable sector screening. [s. 215. (3)]

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 with ensuring that where a criminal reference check is required before a licensee hires a staff member or accepts a volunteer under the LTCH Act 2007, subsection 75(2):
1) the criminal reference check is conducted within six months before the staff member is hired or volunteer is accepted; and
2) the criminal reference check includes a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

A CIR was submitted to the MOHLTC on an identified date related to a missing resident. Review of the CIR revealed that resident #013 eloped from the home and was missing for greater than three hours. The resident was found unharmed and returned to the home by two police officers.

On an identified date, at an identified time, observations by the inspector on the main floor of the facility, revealed a set of double doors leading to the retirement dining room. No staff members were observed supervising the area at the time of observation. This dining room contained an open door leading into a kitchen which contained an open staircase leading to the basement. Staff were observed to be using the dining room doors to access the staircase to the basement. The basement had access to an unsupervised garage area/room with open doors which were labelled "residents/visitors not permitted past this door". The basement also had access to the laundry room, and rooms with exposed electrical wires, neither of which were supervised by staff.

The ED was shown the unlocked retirement dining room doors, and he/she stated that the door to the retirement dining room is usually closed between meals, but not locked as staff use the door. The ED further stated that the unlocked doors could be a potential safety risk if a resident were to go through the doors. [s. 9. (1) 2.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee has failed to ensure that all the staff of the home, including the persons

mentioned in sections 70 to 72 have the proper skills and qualifications to perform their duties.

An interview took place with RN #131 to ascertain his/her knowledge of PSWs being abusive to residents on an identified shift. When asked to explain to his/her role, RN #131 told the inspector that he/she finds the workload on the identified shift to be too demanding because he/she has to administer medications, provide enteral feedings and replace staff who call in sick. RN #131 stated it was “too much".

After speaking with RN #131, the inspector had a conversation with the DOC regarding concerns related to the RN’s communication style, disrespectful description of a resident and workload. The DOC stated he/she had not received any comments from this RN related to workload. The DOC revealed he/she was unaware if this RN had any previous discipline regarding communication or performance and was going to look into his/her personnel file. The DOC then gave the file to the inspector. The inspector reviewed the file for completion of criminal reference checks and training related to the prevention of abuse and neglect.

Review of RN #131’s personnel file also revealed the RN had been disciplined for a number of performance issues including lacking such skills as administrating medications, communicating with family members and co-workers, and failing to provide assessments and proper documentation as required.
- Performance Appraisal from an identified date: Most competencies do not meet expectations; “clinical skills are non-existent.” RN’s performance as a registered nurse is sup-optimal. His/her clinical communication skills are poor. RN #131 being monitored closely by DOC
- Performance Appraisal: from an identified date three years later: RN #131 does not communicate well with families, co-workers, or physician; RN #131 has poor judgment and does not recognize it. Does not have the ability to supervise or mentor staff.

No further follow up noted in RN #131’s file and there was no indication that the home had contacted the College of Nurses of Ontario.
Interview with the current DOC who has only been with the home for approximately nine months, revealed he/she was not aware of RN #131’s performance record and could see that in the past the home had not followed through with their plans to improve his/her performance. The DOC immediately suspended RN #131 pending further investigation. The DOC stated he/she wanted to review and audit RN #131’s documentation and have further discussions with the RN related to her communication style.

Interview with the Administrator confirmed RN #131 lacks skills related to human relations, effective communication skills to handle a variety of interactions with residents, families, staff and the public.

The Administrator further confirmed that RN #131 may lack the proper skills and qualifications, and may not be competent to perform his/her duties based on the home's job description and established professional standards. [s. 73.]

WN #13: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

On an identified date, the MOHLTC received a CIR related to alleged staff to resident abuse which occurred on the same day. Review of the CIR revealed that resident #016 alleged that PSW #158 was rough during care.

Review of resident #016's interdisciplinary team care conference documentation from an identified date, revealed that resident #106 exhibited identified responsive behaviours.

Review of the progress notes by RPN #159, from an identified date, revealed that resident #016 was complaining that PSW #158 had treated him/her roughly and not provided proper care. No injury was observed by staff, and resident #016's most responsible physician (MRP) was informed. The progress note further revealed that resident #016's MRP ordered an identified medication one hour before an identified care task, and RPN #159 informed resident #016's SDM of the change in medications. Resident #016's SDM refused to have the identified medication given to resident #016,

and requested that staff monitor resident #016 for one to two weeks.

In an interview, RPN #159 stated that he/she spoke to resident #016's SDM about identified medication order on an identified date, but the SDM refused the medication and asked for it to be held for one to two weeks.RPN #159 stated that on the same day, he/she communicated the wishes of resident #016's SDM to resident #016's MRP who provided a telephone order to place the identified medication on hold; however, RPN #159 stated that he/she did not transcribe this order into resident #016's digiorder as per the home's process. RPN #159 further stated that he/she could not recall if she called the pharmacy, but he/she informed the evening staff, RPN #132, of the change in medication, and then held the identified medication on two subsequent shifts, as per the SDM's request.

In an interview, RPN #132 stated that he/she received report from RPN #159 that resident #016's SDM had refused the above mentioned identified medication, and that the pharmacy had been informed. RPN #132 stated that the pharmacy called him/her to confirm the hold on the identified medication, but he/she suggested to the pharmacy to send the medication anyway as he/she did not have a confirmation from the doctor or family, and he/she thought that the family may agree to the medication if the order was there, and it was a good idea to have the medication on hand in case the family changed their mind.

Review of resident #016's physician's digiorder revealed a telephone order from resident #016's MRP, transcribed by RPN #159, which stated to give the identified medication one hour before the identified care task on identified days. No subsequent order to discontinue or hold this medication was noted.

Review of resident #016's Electronic Medication Administration Record (EMAR) revealed a schedule for an identified dose of an identified medication to be administered by mouth, on identified days and an identified time starting on an identified date. The EMAR further revealed that the identified medication was held on the order date by RPN #159; administered four days later by RPN #139; held three days after that by RPN #159; and administered four days later by another staff member.

In an interview, RPN #139 stated that he/she administered the identified medication on the above mentioned identified date, to resident #016 as indicated in the EMAR, as he/she was not aware that the medication had been held.

In an interview, ADOC #100 stated that RPN #159 had not followed the home’s process in transcribing the order to put the identified medication on hold into the digiorder, as specified by resident #016’s MRP, as per the request of resident #016’s POA. ADOC #100 further confirmed that as the telephone order from the physician was not transcribed in the physician's digiorder, this resulted in the drug not being administered in accordance with the directions for use specified by resident #016’s MRP. [s. 131. (2)]

Issued on this 19th day of September, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), ANGIE KING (644), BABITHA SHANMUGANANDAPALA (673), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2017_420643_0012
Log No. / No de registre :	008386-16, 023456-16, 027169-16, 027215-16, 029253-16, 003855-17, 006650-17, 007408-17, 008622-17, 011330-17, 011331-17, 011754-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 18, 2017
Licensee / Titulaire de permis :	TENDERCARE NURSING HOMES LIMITED 212 Queen Street East, Suite 202, Sault Ste Marie, ON, P6A-5X8
LTC Home / Foyer de SLD :	TENDERCARE LIVING CENTRE 1020 McNICOLL AVENUE, SCARBOROUGH, ON, M1W-2J6
	Francis Martis

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :

To TENDERCARE NURSING HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

Upon receipt of this compliance order the licensee shall:
1. Provide written communication to all staff of the home instructing them to ensure identified care equipment is not left in common areas where residents can access it.
2. Ensure that identified care equipment is not accessed by residents for safety.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #010.

A Critical Incident System report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to a fall incident involving resident #010 who had fallen from an identified piece of care equipment to the floor resulting in transfer to hospital, where he/she was diagnosed with an identified injury.

Review of resident #010's health records revealed that he/she was assessed to have impaired cognition. Resident #010 had an identified responsive behaviour per an assessment from an identified date.

Review of resident #010's progress notes revealed that at an identified time and date, RN #122 received a call from RN #149 on an identified unit that resident #010 had fallen. The progress notes further indicated that resident #010 was found sitting on the floor next to the above mentioned identified care equipment. Initial assessment was completed and resident #010 was able to move his/her extremities but refused to walk. Resident #010 was later observed to be unable to stand and grimacing in pain and was unable to bear weight. Resident #010 was sent to hospital for assessment.

In an interview, RN #122 stated that resident #010 exhibited an identified responsive behaviour. RN #122 further stated that resident #010 was independent with locomotion, and did not have a history of frequent falls. RN #122 stated that he/she had been called to above mentioned identified unit and found resident #010 to be sitting on the floor, able to move his/her extremeties at the time and was assisted by a PSW to transfer resident #010. RN #122 stated that he/she was unaware why the above mentioned identified care equipment was located in an identified common area, and that this equipment is not for resident use.

In an interview, RN #149 stated that at an identified time he/she was alerted that resident #010 had fallen. RN #149 further stated that he/she was doing documentation at the time and had not noticed resident #010 sitting on the identified care equipment. RN #149 stated that he/she was not aware why the identified care equipment was in the hallway, and that this care equipment is not safe for resident use and should only be kept in a specified location for staff use.

In an interview, RPN #150 stated that resident #010 exhibited responsive behaviours and that it was normal to see resident #010 on the identified unit. RPN #150 further stated that he/she was at the nursing station doing documentation near shift change and did not see resident #010 fall. RPN #150 stated that he/she was not sure why the identified care equipment had been left in the common area, and that this care equipment is not safe for residents who could easily lose balance and fall from them.

In an interview, Physiotherapist (PT) #152 stated that the identified care equipment is not stable for residents to use. PT #152 stated that this care equipment is not safe for residents to use and staff should keep the care equipment where confused residents cannot access them.

Observations by the inspector revealed a piece of the above mentioned identified care equipment in a common area of the unit. There were four residents in the area at the time, three were wheelchair bound, the fourth was ambulatory using a walker. At the time of observation there were no staff members present in the area. In an interview, RPN #157 stated that the above mentioned care equipment was not for resident use and should be kept in a specified location for staff use. RPN #157 further stated that staff are instructed

to not allow residents to use the identified care equipment and remind staff that they are a safety issue.

In an interview, the DOC stated that the identified care equipment should be stored in an identified location, where residents are unable to access them. The DOC acknowledged that as resident #010 had been able to access the identified care equipment in a common area and that the licensee had failed to ensure the home was a safe and secure environment for resident #010.

The severity of this noncompliance was identified as actual harm to resident #010, the severity was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and voluntary plan of correction (VPC) were issued on January 7, 2015, under inspection report #2014_249555_0029 for noncompliance with LTCHA, 2007 S.O. 2007, c.8, s. 5. Due to the severity of actual harm and previous noncompliance with VPC a compliance order is warranted. [s. 5.] (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to residents #012, #016 and #017 as specified in the plan.

The plan will include, at minimum, the following elements:
- A monitoring process to ensure that resident #012 and other residents whose plan of care requires the assistance of two staff members for care receive the appropriate assistance as specified in the plan;
- A monitoring process to ensure that resident #016 and other residents whose plan of care requires the assistance of two staff members for care receive the appropriate assistance as specified in the plan;
- Ensure that resident #017 is assisted with personal care using techniques as specified in the plan.

Please submit the plan to Adam.Dickey@ontario.ca no later than September 5, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #012 as specified in the plan.

Review of a CIR submitted to the MOHLTC, revealed that resident #012 was treated roughly by a PSW. Resident #012's SDM reported that when the resident rang the call bell for assistance, a PSW came into his/her room, spoke loudly and handled him/her roughly. The resident sustained an injury.

Review of the plan of care from the time of the incident, revealed resident #012

required the assistance of two staff members for assistance with identified care tasks. Review of an assessment from an identified date, revealed resident #012 had evidence of injury to an identified area of his/her body. Review of progress notes revealed that on an identified date, x-ray results indicated resident #012 sustained a specified injury.

In an interview, PSW #116 indicated he/she provided care alone to resident #012 at an identified date and time, and had not checked the plan of care. PSW #116 was not aware that resident #012 required two staff to assist with the identified care tasks.

In an interview, RN #156 stated that resident #012 required the assistance of two staff for identified care tasks. In an interview, the DOC acknowledged that the home failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #016 as specified in the plan.

On an identified date, the MOHLTC received a CIR related to an allegation of staff to resident abuse. Review of the CIR revealed that resident #016 alleged that PSW #158 had been rough with the resident while assisting him/her with care.

Record review of resident #016's interdisciplinary team care conference, noted resident #016 exhibited identified responsive behaviours.

Review of the MDS quarterly review assessment from an identified date, revealed that resident #016 had specified disease diagnoses. The MDS assessment further revealed that resident #016 had limited range of motion in identified areas of his/her body.

Review of resident #016's written plan of care noted that resident #016 was impaired related to physical limitation. One of the interventions included two staff to provide extensive to total assistance with identified care tasks.

Review of resident #016's progress notes from an identified date, by RPN #159, revealed that resident #016 stated, PSW #158 had treated him/her roughly and had not provided proper care assistance.

In an interview, resident #016 stated that he/she has limited range of motion in identified areas of his/her body. Resident #016 further stated that one PSW typically assists him/her with the identified care task, and that the care task feels rough.

In an interview, PSW #158 stated that on an identified date, PSW #160 helped him/her transfer resident #016; however, PSW #160 did not stay to assist with resident #016's care, and that he/she completed the identified care tasks on his/her own. PSW #158 further stated that he/she had not reviewed resident #016's plan of care prior to providing care to him/her that day.

In an interview, PSW #160 stated that he/she had assisted resident #016 with a specified care task, but did not provide assistance with the above mentioned identified care tasks.

In an interview, RPN #159 stated that resident #016 exhibits identified responsive behaviours, and that two staff are to provide assistance with the identified care tasks, as per the plan of care.

In an interview, ADOC #100 acknowledged that as PSW #158 completed the identified care tasks for resident #016 without the assistance of another staff member that care was not provided to resident #016 as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #017 as specified in the plan.

MOHLTC received a CIR on an identified date, related to alleged rough treatment. Resident #017 reported to Activation Aide (AA) #151 that PSW #154 was rough during care and hit the resident with an identified object.

Review of resident #017's health records revealed he/she hada history of identified responsive behaviours. Review of resident #017's MDS assessment from an identified date, revealed that he/she exhibited specified responsive behaviours.

In interviews, PSWs #153, #154, RPN #119, ADOC #164 and ADOC #100 stated that the plan of care and kardex were available to all direct care staff on a

mobile Point of Care (POC) tablet for each staff at the nursing station.

Review of resident #017's written plan of care revealed identified strategies to manage resident #017 behaviours. It was also documented that the resident was known to exhibit identified responsive behaviours.

In an interview, PSW #154 stated that he/she was not aware of the interventions detailed in resident #017's plan of care for providing personal care to the resident. PSW #154 further stated that he/she did not review the plan of care or the kardex that was available on the mobile POC tablet.

In interviews, (ADOC) #100 and ADOC #164 stated that the behaviour management interventions were documented in resident #017's plan of care and that PSW #154 did not review and implement the strategies prior to care being provided.

The severity of this noncompliance was identified as actual harm to resident #012, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and voluntary plan of correction (VPC) were issued on February 8, 2016, under inspection report #2016_302600_0001 for noncompliance with LTCHA, 2007 S.O. 2007, c.8, s. 6. (7). Due to the severity of actual harm and previous noncompliance with VPC a compliance order is warranted. [s. 6. (7)] (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

Upon receipt of this compliance order the licensee shall:
1. Review and discuss these findings with all direct care staff as examples of abuse of residents in the home;
2. Ensure that staff are trained on the home's policies on zero tolerance of abuse and neglect and mandatory reporting of alleged, suspected, or witnessed abuse or neglect of a resident;
3. Ensure that the appropriate police force is contacted immediately for incidents of abuse, or neglect of a resident which the home believes may constitute a criminal offence.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Review of a CIR submitted to the MOHLTC on an identified date, revealed an altercation between resident #009 and resident #010. Resident #010 was sent to hospital for treatment of his/her injuries.

Review of resident #009's health records revealed resident #009 was assessed to have cognitive impairment. Resident #009 had limited range of motion in one extremity, and used an identified device for independent ambulation with supervision.

Review of resident #009's progress notes revealed that at an identified date and time, resident #009 exited an identified unit area and exhibited an identified responsive behaviour toward resident #010 resulting in injury. Progress notes revealed resident #009 exhibited an identified responsive behaviour towards a

co-resident which had occurred thirteen days prior to the incident involving resident #010.

Review of resident #010's health records revealed he/she was assessed to have impaired cognition. Resident #010 had an identified responsive behaviour per the MDS assessment.

In an interview, RN #122 stated that he/she was called to an identified unit when the incident occurred. He/she stated that resident #010 had evidence of injury. RN #122 further stated that resident #010 was sent to hospital for treatment. RN #122 stated that resident #010 had exhibited identified responsive behaviours.

In an interview, RPN #144 stated that resident #010 would sit in an identified area of an identified unit. RPN #144 further stated that resident #009 demonstrated an identified responsive behaviour toward resident #010 as resident #009 believed that resident #010 was sitting in his/her chair. RPN #144 stated that resident #009 had a history of demonstrating identified responsive behaviours, but did not recall any other incidents of identified responsive behaviours toward co-residents.

In an interview, RN #148 stated that resident #009 had a disagreement with someone, and had walked out of the identified unit area when he/she exhibited the identified responsive behaviour toward resident #010. RN #148 stated that resident #009 was not known to demonstrate the identified responsive behaviour and that this behaviour was out of the ordinary for resident #009. RN #148 further stated that resident #009's device was taken away and placed in the medication room. RN #148 stated that if resident #009 was known to be aggressive he/she should not have been allowed to use the device as an aid.

In an interview, the DOC acknowledged that in this case, resident #010 had not been protected from abuse by resident #009. [s. 19. (1)] (643)

2. The home has failed to protect resident #012 from abuse.

Review of a CIR submitted to the MOHLTC on an identified date, revealed that resident #012 was treated roughly by a PSW on an identified date. Resident #012's SDM reported that at an identified time, the resident rang the call bell for assistance. A PSW, who was not the resident's primary care giver, came into the room, spoke loudly and handled the resident roughly. According to the resident,

the PSW turned off the call bell, roughly removed the bed table and as the resident assisted by turning onto his/her side, the PSW pushed him/her over further. This was done so roughly that it caused the resident to strike a piece of identified care equipment which caused an injury. The resident complained of pain and x-ray revealed an injury. The home's investigation confirmed that PSW #116 answered the call bell and provided resident #012 care on the above mentioned date.

Record review revealed an assessment completed on an identified date, revealed the resident was assessed to have impaired cognition. Review of the plan of care from the time of the incident, revealed resident #012 required the assistance of two staff members for assistance with identified care tasks. Review of an assessment from an identified date, revealed resident #012 had evidence of injury to an identified area of his/her body. Review of progress notes revealed that on an identified date, x-ray results indicated resident #012 sustained an injury.

During an interview, resident #012 stated that he/she remembered the incident and described and gestured that the PSW was rough with him/her. Resident #012 said he/she struck the identified care equipment causing pain. In an interview, resident #012's family member who reported the incident to RN #156, stated resident #012 told him/her that a PSW, who was not the resident's regular PSW, was rough and yelling. According to the family member, resident #012 stated the PSW pushed him/her so hard that he/she struck the identified care equipment. The inspector observed that the identified care equipment was in a position that would account for such an injury. According to the family member, the resident complained of pain.

In an interview, PSW #116 admitted to providing care alone to resident #012 at the specified date and time, but denied handling the resident in a rough manner. PSW #116 stated he/she was disciplined for this but has never intentionally hurt anyone.

In an interview, RN #132 stated that resident #012's family member reported rough handling on an identified date, which had occurred the day prior. According to the RN, he/she recalled that resident #012 had evidence of injury and was in some discomfort. The RN also indicated resident #012 required the assistance of two people for an identified care task.

In an interview, the DOC acknowledged the home failed to protect resident #012 from abuse. [s. 19. (1)] (501)

3. The licensee has failed to protect resident #002 from abuse.

Review of a CIR revealed resident #002 and his/her SDM reported to the inspector that the resident's regular night PSW screamed at him/her while providing care three to four days ago.

While interviewing resident #002 and his/her SDM regarding a complaint and CIR, resident #002 expressed to the inspector a week ago that someone had screamed at him/her when providing care. The inspector informed the home and a CIR was submitted.

Review of a hand written note by resident #002 which had been provided to the home by the SDM revealed the resident identified PSW #116 as disliking him/her, and disliking assisting resident #002 with identified care tasks because of an identified responsive behaviour.

Record review revealed resident #002 was admitted to the home on an identified date, with an identified diagnosis. Review of resident #002's assessment from an identified date indicated that he/she was assessed to have impaired cognition. Review of resident #002's most recent plan of care revealed the resident requires total assistance with an identified care task. Two staff are required for transfers to and from the bed with a specified piece of care equipment when staff assist resident #002 with the identified care task.

In an interview, PSW #116 stated that resident #002 exhibits identified behaviours. PSW #116 stated he/she asks resident #002 "why you do this?" According to PSW #116, he/she reports to the RPN what has occurred who then comes to check. In an interview RPN #132 stated that PSW #116 reports to him/her when resident #002 exhibits the above mentioned behaviour and he/she will come to assess the situation. According to the RPN, this conversation occurs in an identified unit area that may be overheard by resident #002.

Review of the home's investigation notes revealed PSW #116 admitted to speaking about resident #002 in a public area and would refrain from doing so in the future. Review of a discipline letter to PSW #116 revealed that he/she was being suspended for five days due to resident #002 overhearing him/her saying

something about him/her which made him/her feel very humiliated.

Interview with the DOC acknowledged that the home failed to protect resident #002 from emotional abuse.

The severity of this noncompliance was identified as actual harm to residents #012 and #010, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification and compliance order were issued January 7, 2015, under inspection report #2014_249555_0029 for noncompliance with LTCHA, 2007 S.O. 2007, c.8, s. 19. Due to the severity of actual harm and prior noncompliance with a compliance order a compliance order is warranted. [s. 19. (1)] (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

Service Area Office /
Bureau régional de services : Toronto Service Area Office