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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2019	2019_626501_0010	016761-17, 017661-17, 000333-18, 000427-18, 004713-18, 015199-18, 019822-18, 032370-18, 032664-18, 004398-19, 007329-19	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

SUSAN SEMEREDY (501), AMANDEEP BHELA (746), ANGIEM KING (644)

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): April 18, 23, 24, 25, 26, 29, 30, May 1, 2, 3, 2019.

This inspection was conducted concurrently with complaint inspection #2019_807644_0001.

In this inspection the following intakes were inspected:
#004713-18 related to safe transferring and positioning
#015199-18 related to safe transferring and positioning
#019822-18 related to falls prevention and management
#032370-18 related to falls prevention and management
#004398-19 related to falls prevention and management
#007329-19 related to falls prevention and management
#032664-18 related to falls prevention and management
#016761-17 related to the prevention of abuse and neglect
#017661-17 related to the prevention of abuse and neglect and responsive behaviours
#000427-18 related to the prevention of abuse and neglect and responsive behaviours
#000333-18 related to the prevention of abuse and neglect and responsive behaviours

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Social Worker, Physiotherapists (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), occupational therapist (OT), registered dietitian (RD), substitute decision-makers (SDM), family members and residents.

During the course of the inspection, the inspectors reviewed health care records, the home's investigation notes, relevant policies and procedures and observed the delivery of resident care and services, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **4 WN(s)**
- **1 VPC(s)**
- **0 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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).

Findings/Faits saillants :

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

The home submitted two critical incident system (CIS) reports related to resident #001 having fallen and being transferred to the hospital. One report was submitted on an identified date stating resident #001 had fallen, was sent to the hospital and was diagnosed with an injury. Another report was submitted on an identified date stating resident #001 had fallen, was sent to the hospital and was diagnosed with another injury.

A review of resident #001's current plan of care indicated the resident was at high risk for falls and a device was to be placed on the resident's mobility aide for safety in order to alert staff when they attempted to get up. The device was to be transferred to the bed when the resident was in bed.

On an identified date, at an identified time, the inspector observed resident #001 in the dining room sitting in their mobility aide with no device applied. An interview with Personal Support Worker (PSW) #101 indicated they thought the resident was supposed to have a device but because they had just returned from vacation, thought this might have changed. The PSW admitted they failed to verify this with registered staff. A short time later, the inspector, along with PSW #101 and Registered Nurse (RN) #102, observed that a device was on resident #001's bed. Further interviews with PSW #101 and RN #102 confirmed resident #001 should have had the device placed on the resident 's mobility aide.

An interview with Director of Care (DOC) #104 acknowledged that because staff failed to put a device in place for resident #001 as in the above noted incident, they failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. The home submitted a CIS report to the MOHLTC related to resident #002 being found on the floor at the bedside, on an identified day, with identified injuries. The resident was sent to the hospital and received treatment.

A review of resident #002's most recent plan of care identified the resident was at high risk for falls as evidenced by multiple falls related to identified medical conditions. One of the interventions to prevent falls was for staff to ensure the resident had good fitting shoes and wore them. Review of a physiotherapist (PT) post fall assessment on an identified date, indicated the resident's shoes were worn improperly. Review of a further PT post fall assessment, indicated the resident should use well-fitting shoes.

On an identified date, the inspector observed resident #002 resting in their bed, at an identified time. The inspector observed that there was an identified type of footwear beside the bed with a portion pushed down. An interview with PSW #106 indicated that the resident wears these on the unit but when they go outside or downstairs, they wear other identified shoes.

On another identified date, the inspector observed resident #002 standing at an area of the unit wearing an identified type of footwear with a portion pushed down. The inspector then observed the resident walking very unsteady down the hallway with PSW #110. An interview with PSW #110 indicated they were not resident #002's primary care giver and they did not know whether the footwear the resident was wearing was appropriate. An interview with PT #111 who observed the footwear resident #002 was wearing, stated that they were not appropriate. The PT noted that appropriate footwear was available for resident #002 in their room area and stated staff should ensure that these are worn at all times.

An interview with RN #115 indicated resident #002 had not been wearing good fitting shoes on the above noted date. Interviews with RN #115 and DOC #104 confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan. [s. 6. (7)]

3. The home submitted two CIS reports to the MOHLTC related to resident #002 having an altercation with resident #005. Resident #005 sustained an injury and was sent to the hospital for further assessment. Resident #005 was admitted to the hospital.

A review of resident #002's most recent plan of care indicated the resident has responsive behaviours that have been exhibited to staff and other residents. An intervention to respond to such behaviours is one to one staff monitoring. A review of a progress note on an identified date indicated resident #002 had one to one staff monitoring during identified times.

An observation by the inspector on an identified date, at an identified time, indicated resident #002 did not have one to one staff monitoring them. An interview with Registered Practical Nurse (RPN) #150 indicated the one to one staff went on break. Assistant Director of Care (ADOC) #151, who was present at the time of the observation, acknowledged that the home's staff needed to replace the one to one staff when they went on break.

An interview with DOC #104 stated resident #002 was to have had one to one staff monitoring on the above noted date and time. The DOC acknowledged that the expectation of the home is for one to one staff to be replaced when they go on break and confirmed the home failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect resident #005 from abuse by resident #002.

The home submitted two CIS reports to the MOHLTC related to resident #002 having an altercation with resident #005 on an identified date. Resident #005 was admitted to the hospital with an identified injury.

A review resident #002's progress notes indicated that there had been three previous altercations between resident #005 and #002.

A review of resident #005's plan of care before the above incident, indicated resident #005 walked with a mobility aide. A review of resident #005's current plan of care indicated the resident requires one staff to provide extensive assistance to push their mobility aide from location to location on and off the unit as they are able to propel their mobility aide for short distances only.

Interviews with staff indicated resident #005 was a trigger for resident #002's responsive behaviours. An interview with RN #141, RPN #122, and PSW #147 indicated resident #005 would often talk and make gestures towards resident #002. An interview with PSW #147 indicated that before resident #005 sustained the above noted injury, they used to walk with a mobility aide but were now using another mobility aide for locomotion . According to PSW #147, resident #005 used to need limited assistance with most of the activities of daily living (ADLs) but now required extensive assistance.

An interview with DOC #104 acknowledged steps had not been put in place to respond to resident #005 being a trigger for resident #002's responsive behavioiurs and confirmed the home failed to protect resident #005 from abuse. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions, were documented.

The home submitted a CIS report to the MOHLTC related to resident #003 falling and sustaining an identified injury. The report indicated the resident had a tendency to get up and walk without a mobility aid and not call for assistance. It was noted in the report that the plan of care at the time of the fall indicated that one of the interventions was to have an identified device applied on the bed and ensure that it was working well. It was noted that at the time of the fall, the device was applied but was not working.

A review of resident #003's plan of care indicated the resident was at universal precautions for falls. One of the interventions in place was to have a device applied on the bed and ensure it was working well. Review of PSW task records indicated this intervention was not assigned as a task and therefore PSWs had not documented whether it was completed.

An interview with PSW #113 indicated they recalled finding resident #003 during the night shift when the above noted fall occurred but could not recall if the device was working. PSW #113 stated they had checked the device when they came on shift and it had been working but could not recall documenting this anywhere.

An interview with ADOC #114 indicated they could not recall if anyone followed up regarding the issue of the above mentioned device not working and there was no documentation to indicate that any investigation was done regarding the device not working. The ADOC further indicated that documentation of PSWs checking such devices has been something the home has done inconsistently. The ADOC acknowledged that documentation of this intervention would be helpful to ensure devices are applied and in good working order.

The home failed to ensure that the intervention of applying a device and ensuring it was in good working order was documented. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, to minimize the risk of altercations and potentially harmful interactions between and among residents.

The home submitted two CIS reports related to resident #002 having an altercation with resident #005 on an identified date. Resident #005 was admitted to the hospital and was diagnosed with an identified injury.

According to resident #002's plan of care, the resident had responsive behaviours. A review of resident #002's progress notes indicated the resident was being followed by external behaviour consultants.

A review of resident #002's progress notes indicated that on an identified date, resident #002 had an altercation with resident #005. When RN #141 tried to separate the residents, resident #002 continued to exhibit an identified responsive behaviour towards both of them. Further review of resident #002's progress notes indicated that five days later resident #005 and resident #002 had two separate altercations and RPN #122 was injured during one of these altercations.

Further review of resident #002's progress notes eight days later indicated resident #002 had another altercation with resident #005. Both residents were sent to the hospital.

A review of resident #002's written plan of care and progress notes from the above noted time period, indicated there were no additional procedures or interventions developed or implemented to minimize the risk of altercations and potentially harmful interactions between residents, specifically between resident #002 and #005.

Interviews with RN #141, PSW #124, RPN #122 and RPN #126 indicated resident #005 was a trigger for resident #002 during the above mentioned time period.

An interview with ADOC #114 indicated resident #005 was a trigger for resident #002 and 24-hour one to one monitoring was implemented after resident #002 returned back to the home after the last incident between resident #002 and #005. An interview with DOC #104 indicated they could not recall previous altercations between resident #002 and #005 but acknowledged that not enough was put in place to prevent further altercations after the first incident.

The home failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours. Resident #005 was a known trigger for resident #002 and no interventions were developed and implemented that minimized the risk of altercations and potentially harmful interactions between resident #002 and #005. [s. 55. (a)]

Issued on this 27th day of May, 2019

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

Original report signed by the inspector.