Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: January 30, 2024

Inspection Number: 2023-1157-0007

Inspection Type:
Critical Incident
Follow up

Licensee: Tendercare Nursing Homes Limited

Long Term Care Home and City: Tendercare Living Centre, Scarborough

Lead Inspector	**Inspector Digital Signature**
Natalie Jubian (000744)	Natalie Jubian Digitally signed by Natalie Jubian Date: 2024.02.06 13:15:14 -05'00'

Additional Inspector(s)
Ana Best (741722)
Rexel Cacayurin (741749)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 2 to 5, 8, and 10, 2024.
The inspection occurred offsite on the following date(s): January 9, 2024.

The following intake(s) were inspected:
- Intake related to an alleged resident to resident abuse incident.
- Intake related to an alleged staff to resident neglect.
- Intake - First follow-up to Compliance Order #001/Inspection #2023_1157_0006 - FLTCA, 2021 - s. 184 (3) related to Directives by the Minister, Compliance Due Date (CDD) of November 30, 2023.

- Intake- First follow-up to Compliance Order #002/Inspection #2023_1157_0006 - O. Reg. 246/22 - s. 123 (3) (a) related to Medication Management System, CDD of November 30, 2023.
- Intake related to resident fall with injury.
- Intake related to a medication incident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1157-0006 related to FLTCA, 2021, s. 184 (3) inspected by Ana Best (741722)

Order #002 from Inspection #2023-1157-0006 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Ana Best (741722)

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

Pain management

s. 57 (1) The pain management program must, at a minimum, provide for the following:

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee failed to ensure strategies were initiated to manage a resident's pain post fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the pain program, at a minimum, provides strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices, and assistive aids. Specifically, the registered staff did not comply with the licensee's Pain Identification and Management policy when a resident complained of pain post-fall, and their pain was not managed.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding the fall of a resident that resulted in injury.

The resident's post fall pain assessment, indicated they had complained of pain. The home's Pain Identification and Management policy indicated the home would utilize an interdisciplinary approach to pain management and non-pharmacological methods would be explored as appropriate. The home's Falls Prevention and

Management policy indicated to treat any injuries and manage pain, and to complete a pain assessment every shift for seventy-two hours post fall.

Three progress notes within the resident's clinical records indicated the resident had complained of pain. A pain level had been documented by Registered Practical Nurse (RPN) #108 on the same day as the fall. The resident had a medication order for pain which was not administered.

RPN #108 confirmed the medication had not been administered and no non-pharmacological interventions had been trialed to manage the resident's pain.

Failing to provide pain interventions post fall to the resident resulted in unmanaged pain.

Sources: The resident's clinical records, home's pain identification and management policy, home's falls prevention and management policy, and interviews with staff. [000744]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee failed to ensure a resident's pain was monitored post-fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the pain program, at a minimum, provides for monitoring of residents' responses to, and the effectiveness of, the pain management strategies. Specifically, the registered

staff did not comply with the licensee's Pain Identification and Management policy when a resident complained of pain post-fall, and their pain was not assessed and strategies not implemented.

Rationale and Summary

A CIR was submitted to the Director regarding the fall of a resident that resulted in injury.

The resident's post fall pain assessment indicated they had complained of pain. The home's Pain Identification and Management policy indicated upon new onset of pain, a comprehensive pain assessment is to be completed using the electronic pain assessment. The electronic pain assessment should include the following: location, provoking factors, quality, radiation, severity, timing, what effect the pain has on the resident, the resident's values, and history of pain and how it has been managed. The home's Falls Prevention and Management policy indicated a pain assessment should be completed every shift for seventy-two hours post fall.

The resident's clinical records indicated a pain assessment was not completed on the evening shift after the resident had complained of pain, and no interventions had been implemented to manage their pain. A pain level had been documented by RPN #108 on the same day as the fall, however a comprehensive pain assessment had not been completed on the shift. The resident had an order for pain medication which was not administered. Further, a comprehensive pain assessment was completed by Registered Nurse (RN) #110 on the following shift after the fall, however used the pain level documented previously by RPN #108. No other pain assessments were completed throughout the shift.

RPN #108 confirmed an electronic comprehensive pain assessment was not completed for the resident post fall and no interventions had been implemented to manage their pain.

Failing to complete a comprehensive pain assessment and implementing interventions resulted in the resident's unmanaged pain.

Sources: The resident's clinical records, home's pain identification and management policy, home's falls prevention and management policy, and interviews with staff. [000744]