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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: March 5, 2025

Inspection Number: 2025-1157-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Tendercare Nursing Homes Limited

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 24-27, 2025 and March 3-5, 2025

The following intake(s) were inspected:

- Intake related to an alleged resident to resident sexual abuse incident
- Intake related to an alleged resident to resident physical abuse incident
- Intake related to a resident fall resulting in injury and subsequent transfer to hospital
- Intake related to a complaint regarding multiple resident care items.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

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

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The licensee failed to protect resident #002 from sexual abuse from resident #001.

Ontario Regulation (O. Reg) 246/22 section (s.) 2 defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Personal Support Worker (PSW) #104 witnessed resident #001 approach resident #002 and touch the resident inappropriately. Registered Practical Nurse (RPN) #103 stated that resident #002 would not have the capacity to provide consent. Prior to the incident, staff had seen resident #001 sitting beside resident #002 and failed to separate them.

Sources: Critical incident report, resident #001 and #002's clinical records, home's investigation notes, interviews with staff.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of neglect towards a resident was immediately reported to the Director. A PSW did not attend their one-to-one shift for one hour without notifying the nurse. The Director of Care (DOC) confirmed the allegation of neglect was substantiated as the resident did not receive care by the PSW for one hour. The incident was not reported to the Director as required.

Sources: Home's investigation notes, staff employee file, Interview with DOC.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure a resident received weekly skin and wound assessments related to an area of altered skin integrity. A review of the resident's clinical records identified an initial skin and wound assessment being completed the day the resident sustained the wound and the last skin and wound assessment

completed was noted two days later, indicating the wound was still present. No other skin and wound assessments were completed for the resident's area of altered skin integrity. RPN #102 confirmed weekly skin and wound assessments should have been completed for the resident's altered skin integrity until healed.

Sources: The resident's clinical records and interview with RPN #002.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident began demonstrating sexual responsive behaviours that actions were taken to respond to the needs of the resident including assessments, reassessments and interventions and that the resident's responses to the interventions were documented.

The resident's clinical records indicated they began demonstrating sexually inappropriate behaviours in a specified time. The resident's care plan did not include interventions related to sexual expressions until months later.

Furthermore, two Dementia Observational System (DOS) assessment tools for the resident, who demonstrated responsive behaviours, were not completed as per the expectations of the home.

RPN #103 acknowledged that staff did not complete the DOS assessments as per the expectations of the home and that interventions for the resident's sexual behaviours should have been in place sooner.

Sources: Clinical records for the resident, DOS Assessments, and interviews with staff.

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