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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2015	2014_294555_0029	O-001110-14	Resident Quality Inspection

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

GWEN COLES (555), KATHLEEN MILLAR (527), KELLY BURNS (554), MATTHEW STICCA (553), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 10, 11, 12, 13, 14, 17, 18, 19 and 20, 2014.

Inspections were done concurrently related to Critical Incident Logs #T-491-14; #T-638-14; #T-642-14; #T-833-14; and Complaint Logs #T-254-14/O-000006-14; #T-1007-14.

During the course of the inspection, the inspector(s) spoke with the President; Executive Director (ED); the Director of Care (DOC); the Assistant Director of Care (ADOC); the Environmental Services Manager (ESM); the Food Services Manager (FSM); Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); Maintenance Staff; Housekeeping Staff; Dietary Aides; Family Council members; Resident Council members; Social Worker; Family Members; Sitters; and Medical Director.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

17 WN(s)
2 VPC(s)
1 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. 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 ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

- As per LTCHA, 2007 S.O. 2007, c. 8, s. 20 the licensee failed to ensure that the Home's policy entitled "Resident Abuse – Staff to Resident" was complied with (as identified in WN#5).
- As per LTCHA, 2007, S.O. 2007, c.8, s. 23 the licensee failed to ensure that an immediate investigation of an alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff was taken; appropriate actions were taken in response to every incident; and any requirements that are provided for in the regulations for investigating and responding as required were complied with. (as identified in WN#6).
- As per LTCHA, 2007, S.O. 2007, c. 8, s. 24 the licensee failed to ensure that the Director was immediately notified when there was an alleged, suspected or witnessed incident of abuse (as identified in WN#7).
- As per LTCHA, 2007, S. O. 2007, c. 8, s. 76 the licensee failed to ensure that all persons receive retraining in Resident Rights, Zero Tolerance of Abuse/Neglect, Duty to Report and Whistle Blowing Protection (as identified in WN #11).
- As per O.Reg 79/10, s. 97 the licensee failed to ensure that the Resident's Substitute Decision Maker (SDM) was notified within 12 hours of any alleged, suspected or witnessed incident of abuse or neglect (as identified in WN #13).
- As per O. Reg 79/10, s. 99 the licensee failed to ensure that all alleged, suspected or witnessed incidents of abuse or neglect are considered in the annual program evaluation and that the program evaluation is completed (as identified in WN #14). [s. 19. (1)]

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. 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 is a safe and secure environment for its residents.

On November 10, 2014 at 11:30 hrs the door leading to the garbage chute on the 3rd floor was not locked and the chute had no latch. The inspector was able to fully open the chute. A resident bedroom is located in the same side hallway as this chute and in close proximity to this door.

The unsecured garbage chutes was immediately brought to the attention of the DOC who indicated that the door leading to the garbage chute should be locked all the time.

The DOC and ESM indicated that the lock on the door leading to the garbage chute was broken and a new lock was installed on November 10, 2014.

This unrestricted, unsupervised access to the garbage chute presented a potential risk of injury at residents on the 3rd floor and has subsequently been corrected. All other garbage chutes were secured. [s. 5.]

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 that all doors leading to garbage chutes are locked when unsupervised, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) the home, furnishings and equipment are kept clean and sanitary; and (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Inspector #527 observed on November 10 and 12, 2014 in the 2nd Floor Dining Room: broken,unclean tiles; unclean walls and tables; rusted taps, stained counters.

The home's cleaning checklists for the 2nd Floor dining room for the months of August, September and October 2014 were reviewed and they were inconsistently signed off by the staff that the cleaning tasks were completed. [s. 15. (2)]

2. The following observations were made during the dates of November 10, through to November 14, 2014: tables, walls, ceiling, floors, vanities, transfer and bath equipment were found to be soiled.

Environmental Services Manager indicated that the home does have cleaning schedules in place, which are as follows:
- all resident rooms are cleaned on a daily basis including around the toilet, and wet mopping of the floors both in resident rooms and washrooms;
- tub and shower rooms are cleaned daily (toilet, and wet mopping of floors) and deep cleaned weekly (floors and shower stalls)
- Dining rooms are deep cleaned monthly, but daily floors are washed.

The ESM commented that he too noticed cleaning deficiencies on the second floor and would be addressing identified issues with housekeeping staff; ESM stated that approval has been received as of November 13, 2014 to bring in extra staff to provide additional cleaning to both the second and third floors of the home.

The Executive Director indicated that it is the expectation that the home is kept clean and sanitary at all times. [s. 15. (2) (a)]

3. The following observations were made: drywall damage; cracked tiles or laminate; tiling pulling away from the walls with the sub-flooring exposed; chipped or damaged paint on door frames; wall guard or baseboard loose, lifting or torn; cracks in ceilings rooms; damaged toilet rails (over toilet), basin rack holders and transfer poles; broken towel rack; chipped vanities and sink; loose drain covers; torn wallpaper, door push bar taped at the corner.

The ESM indicated being aware of a few of the identified maintenance deficiencies indicated above but was not aware of all areas listed and commented that the department relies on staff throughout the home to communicate needed repairs and or damage to the maintenance staff via the homes electronic maintenance requisition.

The ESM indicated that the home was an older home and it was difficult to keep up with the needed repairs. The ESM also indicated that the maintenance department prioritizes repairs based on safety risk. [s. 15. (2) (c)]

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 home, furnishing and equipment are kept clean and sanitary, and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be afforded privacy in caring for his or her personal needs is respected and promoted.

On November 13, 2014 it was observed that a resident's bedroom and bathroom doors were open, and a staff member could be seen assisting the resident with changing an incontinence product. During an interview conducted with the observed staff member who reported that the expectation for privacy when performing personal care is to ensure privacy curtains are drawn, and bathroom and bedroom doors are closed. During an interview conducted with DOC on November 13, 2014 who reported that the expectation for resident privacy during personal care is to ensure curtains are drawn and doors are closed. [s. 3. (1) 8.]

WN #5: 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 failed to comply with LTCHA, 2007, s. 20 (1), by ensuring that the home's policy called "Resident Abuse - Staff to Resident", policy number OPER-02-02-04, revised November 2013 was complied with.

Related to Log # T-638-14:

A family reported to a staff member that another staff member handled and spoke to a resident in an appropriate manner. The staff member did not report this incident to anyone in management until three days later. The DOC notified the Director ten days after the alleged abuse incident.

- The home's policy "Resident Abuse - Staff to Resident" states on page 3 that "The Administrator / Director of Care / Designate document pertinent details of the investigation, actions taken during the investigation, and any actions taken as a result of the outcome of the investigation. Keep this documentation in a secure location." After the home completed their investigation the DOC and the ED confirmed the verbal abuse of the Resident, but were unable to substantiate any physical abuse, and were unable to locate any investigative notes related to the incident, which would have outlined the pertinent details, interviews with staff, and actions taken. The DOC and ED confirmed they were unable to find any investigative notes for this critical incident investigation, and were not in compliance with the policy.

- The home's policy "Resident Abuse - Staff to Resident" states on page 4 under evaluation: "The evaluation of the abuse policy is outlined in the program evaluation document. This document must be update at least annually. The evaluation covers:
- Analysis of the policy related to abuse and neglect
- Effectiveness of policy to support zero tolerance approach to abuse and neglect
- Results of all abuse analysis are integrated into the evaluation
Changes recommended and or made to prevent abuse are formalized, communicated, and implemented promptly."
In reviewing the Annual Program Evaluation for Resident Abuse, there was no analysis of the policy and the effectiveness of the policy to support zero tolerance. The number of abuse cases in the home for 2013 were missing one physical abuse and one neglect case, therefore they were not integrated into the evaluation. The ED and DOC confirmed there was no meeting minutes to support that the analysis was completed, and there was no documentation on the program evaluation document to support compliance with the home's policy.

- The home's policy "Resident Abuse - Staff to Resident" on page 4 states "All staff must receive education during orientation and annually thereafter, on Resident Abuse - Staff to Resident policy as well as policies and procedures that support identifying and preventing resident abuse." In reviewing the annual education for 2013, out of the 316

staff in the home there was only 174 who received training. The DOC confirmed the home did not train all staff in 2013 as required under the legislation. The policy was not complied with as it relates to minimum education requirements outlined in the home's policy. [s. 20. (1)]

2. Related to Log # O-006-14:

According to documentation, the Assistant Director of Care (ADOC) received a phone call from a family member alleging neglect in care of a resident. Documentation indicated the ADOC telling family that the home had been experiencing staffing shortages and that an investigation into the concerns would be initiated.

The home's policy "Resident Abuse – Staff to Resident" (OPER-02-02-04) directs the following:
- Every person in the home, including staff, has a mandatory and legal obligation to immediately report suspected or witnessed abuse
- All reported incidents of abuse will be objectively, thoroughly, promptly and accurately investigated. (Note: the homes definition of abuse includes neglect)
- Anyone who suspects or witnesses abuse and or neglect that causes harm or may cause harm to a resident is required by the LTCHA 2007 to contact the MOHLTC Action Line
- Immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care, or their designate (e.g. supervisor, department head) who must report the incident, as required by provincial legislation and jurisdictional requirements (e.g. MOHLTC Director through Critical Incident Reporting System / after -hours pager)
- Initiate an internal investigation and complete a preliminary report before going off duty; ensure comprehensiveness of all investigative documentation; document pertinent details of the investigation, actions taken during the investigation and any actions taken as a result of the outcome of the investigation. Keep this documentation in a secure location.

Based on the following information, the home's policy was not followed:
- The ADOC, who received a phone call from the family member specific to neglect of care, indicated not calling MOHLTC immediately and further indicated that it is up to the DOC and/or ED to determine what is reportable to MOHLTC.
- The ADOC indicated no recall specific to the family's phone call (allegation of neglect of care) despite clinical documentation evidence. The ADOC could not remember if an investigation was completed nor could the ADOC locate any investigation notes

pertaining to family's concerns.
- The DOC confirmed no investigation was completed as the allegation was considered untrue and therefore did not take any actions to determine if there are reasonable grounds related to the alleged neglect.
- The DOC and the ED indicated that a Critical Incident Report was not completed for the incident alleging neglect of care.

The ED and DOC both confirmed that the home's policy specific to Resident Abuse - Staff to Resident is to be followed. [s. 20. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Related to Log # O-006-14:

The licensee failed to comply with LTCHA, 2007, s. 23 (1) (a), by ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (ii) Neglect of a resident by the licensee or staff.

A family member of a Resident expressed alleged neglect related to personal care of a resident. The family indicated approaching staff to voice concerns and was told that there was not enough staff and resident care would have to wait. According to clinical documentation the Assistant Director of Care (ADOC) received a phone call from the family regarding care concerns; and notes indicate the ADOC telling family that the home had been experiencing staffing shortages, and that an investigation into the concerns would be initiated.

During an interview, the ADOC was unable to recall which staff member received the initial care concern and as a result the Inspector was not able to interview the staff member. The ADOC indicated the home was short staffed on that date and staffing shortages may have resulted in delays in resident care. The ADOC was unable to locate investigation notes specific to Family's concerns and could not recall the incident or if there had been an investigation despite documentation of receipt of a family's phone call. The ADOC commented that most likely the complaint was untrue.

The DOC indicated that there was no investigation completed for the family's concern as it was felt the complaint was untrue and therefore did not take any actions to determine if there are reasonable grounds related to the alleged neglect of the resident.

The ED confirmed that there was no investigation notes specific to the complaint of the Family member for the dates indicated above. The ED stated that the home's practice is to investigate all allegations of abuse and or neglect. [s. 23. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to Log # O-006-14:

The licensee failed to comply with LTCHA, 2007, s. 24 (1), by ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 5., for the purpose of the definition "neglect" in subsection 5, of the Act and this regulation, "neglect" means, failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A family member of a Resident expressed alleged neglect related to personal care of a resident. According to clinical documentation the Assistant Director of Care (ADOC) received a phone call from the family regarding care concerns related to the Resident and indicated telling the Family that the home had been experiencing staffing shortages.

During an interview, the ADOC was unable to recall which staff member received the initial care concern from the family. The ADOC indicated the home was short staffed and

staffing shortages may have resulted in delays in care for the Resident.

The ADOC indicated that the neglect allegation was not reported to the Ministry of Health and Long Term Care, but did report the family concerns to the DOC. The ADOC indicated that the practice of the home is for staff to report allegations, suspected or witnessed abuse and or neglect to the DOC and/or the ED and they will determine if such is reportable or not reportable to the MOHLTC (Director).

The ADOC and the DOC commented feeling the allegation was untrue and therefore did not take any actions to determine if there are reasonable grounds related to the alleged neglect of the Resident.

The ADOC, DOC and ED all stated that the Ministry of Health and Long Term Care was not contacted as to the allegation of neglect of care and all were aware of reporting requirements under Section 24. [s. 24. (1)]

2. Related to Log # T-638-14:

A family reported to a staff member that another staff member handled and spoke to a resident in an appropriate manner. The staff member did not report to anyone in management until reporting to the DOC three days later. The DOC did not report the alleged abuse to the Director until 10 days later. There was a ten day delay in reporting to the Director the alleged abused of said Resident. The ED and DOC confirmed there was a delay in immediately reporting the alleged abuse to the Director. [s. 24. (1)]

3. Related to Log # T-833-14:

A Staff member reported to the ADOC that another staff member was observed to have one hand on a Resident's arm and the other on the back of the Resident's neck. Staff was reported as trying to redirect the Resident by use of their hands. Staff stated that the other Staff member was “forcefully” trying to redirect the resident. When asked what "forcefully" meant, Staff indicated that they witnessed the other Staff member push the back of the Resident's neck and grab their arm. Both Staff indicated that the Resident was at a high risk for falls at the time of the occurrence, and this information was confirmed in Resident’s care plan specific to the date of the incident. The Resident was also identified as having wandering tendencies. The Staff member indicated that other Staff's actions were putting the Resident at risk for a fall. The Director was notified of this incident four days later.

In an interview on November 18, 2014 the ADOC indicated was unable to accurately recall the event. The ADOC indicated that they were unable to provide documented evidence to state that the Director was immediately notified. The ADOC indicated that their role is if the ED or DOC is in the building; the ADOC would let one of them know of the incident of abuse. Then the ED or the DOC would notify the Ministry of Health (MOH) of the incident. If it was after hours, the ADOC would notify the Director themselves, the number is located at the front desk.

On November 18, 2014 the reporting Staff member indicated that the DOC was seen "leaving the building" on the date of the incident and therefore the Staff member reported the incident to the ADOC.

In an interview on November 18, 2014 the DOC indicated that the Director was made aware of the incident involving Resident when the Critical Incident Report was submitted four days later.

In an interview on November 18, 2014 the ED indicated that the home was made aware when Staff reported the incident to ADOC, however there is no documented evidence that the Director was immediately notified. The Director was notified was when the Critical Incident Report was submitted four days later. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. Related to Log # T-1007-14:

The licensee has failed to ensure that there is a written staff plan for the nursing and personal support services program.

Review of Quality Program Evaluation "Nursing and PSW Staffing Services" signed July 4, 2014 indicated a "Formal staffing plan B is in the works".

Interviews conducted with the ED and the DOC on November 19, 2014 who both reported that a written staffing plan including a back-up plan for situation when staff cannot come to work was not available.

A un-dated document entitled "Current Staffing Plan" which included Directives for Contingency Staffing was provided to the inspector on November 19, 2014 by the DOC who reported it was created on November 19, 2014. [s. 31. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 37 (1) (a), by ensuring that resident have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

The following observations were noted: unlabelled personal items such as combs, toothbrushes and denture cups were found in shared bathrooms.

The DOC indicated that all care items are to be labelled for individual resident use. [s. 37. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (6) The following persons may not be members of the Family Council:
1. The licensee, and anyone involved in the management of the long-term care home on behalf of the licensee. 2007, c. 8, s. 59 (6).
2. An officer or director of the licensee or of a corporation that manages the long-term care home on behalf of the licensee or, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129, as the case may be. 2007, c. 8, s. 59 (6).
3. A person with a controlling interest in the licensee. 2007, c. 8, s. 59 (6).
4. The Administrator. 2007, c. 8, s. 59 (6).
5. Any other staff member. 2007, c. 8, s. 59 (6).
6. A person who is employed by the Ministry or has a contractual relationship with the Minister or with the Crown regarding matters for which the Minister is responsible and who is involved as part of their responsibilities with long-term care home matters. 2007, c. 8, s. 59 (6).
7. Any other person provided for in the regulations. 2007, c. 8, s. 59 (6).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007, s. 59 (6) whereby the licensee did not ensure that following persons may not be members of the Family Council:
1. The licensee, and anyone involved in the management of the long-term care home on behalf of the licensee.
4. The Administrator.
5. Any other staff member.

On November 13, 2014 the ED and DOC confirmed to Inspector #570 that the Family Community Advisory Board is considered as the Family Council.

On November 13, 2014 interview with the ED indicated he is a member of the Advisory Board as a treasurer. The DOC, ADOC, and Program manager attend meetings to provide updates. They attend as invited guests.

On November 13, 2014 during a phone interview conducted with Secretary of the Family Council indicated that the Family Community Advisory Board is also the Family Council. Members of the council include Administration staff and family members. The Board oversees the Foundation and the ED is the treasurer of the Foundations and he provides reports. [s. 59. (6)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. Related to Log # T-254-14/O-006-14:

The licensee failed to comply with LTCHA, 2007, s. 76 (4), by ensuring that all staff have receive retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protection.

A review of staff education / training records for 2013 specific to Resident Rights, Zero Tolerance of Abuse/Neglect, Duty to Report and Whistle Blowing Protection indicated that 174 employee's attended mandatory training.

The DOC indicated that there were approximately 316 employees employed by the home, but only 290 are regularly working within the home. The DOC confirmed that not all employees employed by TenderCare completed mandatory education in 2013 specific to the above indicated topics. [s. 76. (4)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Resident's Council in developing the satisfaction survey.

Interview with the Resident Council President on November 14, 2014 who was uncertain regarding the Resident's Council involvement in development and carrying out of satisfaction survey. Interview with a Staff involved with the Resident Council on November 17, 2014 who reported that the satisfaction survey is developed by the corporate office of the licensee and the home's Resident Council is not involved in the development of the survey. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Related to Log # T-833-14:

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was notified within 12 hours upon becoming aware an alleged incident of abuse.

A Staff member witnessed another staff member "forcefully" redirecting a resident down the hall. This was defined by the staff member as grabbing a limb and applying force to the resident's body to try and redirect the resident.

Review of the resident's clinical records over a one month period noted an entry was made indicating that the Resident's SDM was notified approximately 4 days after the incident occurred. [s. 97. (1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that every incident of abuse or neglect of a resident at the home was considered in the evaluation.

In reviewing the 2013 Annual Program Evaluation for Resident Abuse the number of abuse cases in the home was missing one resident physical abuse case and one neglect case, therefore they were not integrated or considered in the evaluation. The ED and the DOC confirmed that the two abuse and neglect cases were not considered in their 2013 program evaluation. [s. 99. (c)]

2. The licensee has failed to ensure (a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it; (b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences; (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation; (d) that the changes and improvements under clause (b) are promptly implemented; and (e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The Resident Abuse Program Evaluation for 2013 was signed off by the ED on February 13, 2014. There was no actions identified from the analysis; there was three objectives for 2014 however no outcomes were identified, and no dates for the implementation of the changes. The ED and DOC were unable to provide any further documentation of an action plan for implementation of the home's objectives and any measurable outcomes. The ED and DOC confirmed the written record of the 2013 Program Evaluation for Resident Abuse was incomplete and did not have the documented requirements. [s. 99. (e)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Related to Log # T-642-14:

The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

The home identified during the drug destruction process that seven ampoules of morphine were broken at the neck and empty. The home did not notify the Director of the unaccounted for controlled substance until eight days after the critical incident. The ED and DOC confirmed they did not report the critical incident no later than one business day of the occurrence. [s. 107. (3) 3.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

It was observed during the inspection that a medication cart was found unsecured near the entrance to a Dining Room without any registered staff member in attendance. Residents were in close proximity to the cart. The Inspector remained in attendance until a registered staff member returned to the unit. Interview conducted with a registered staff member who reported that this cart was the responsibility of this staff member, and who indicated that the cart had been secured prior to leaving the floor. Staff reported the expectation was for medications carts to be secured when staff were not in attendance. Staff then secured the medication cart. [s. 130. 1.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 229 (4), by ensuring that all staff participate in the implementation of the infection prevention and control program.

The following observations were made during the week of November 10, through to November 14, 2014:
- unlabelled wash basins, bedpans, and urinals in a shared (semi) washrooms.

Staff interviewed indicated that all bedpans and urinals are to be labelled for individual resident use.

The DOC confirmed that bedpans and urinals are to be labelled and are not to be stored in communal or shared areas; and all are resident care items are to be labelled for individual resident use. [s. 229. (4)]

Issued on this 9th day of January, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GWEN COLES (555), KATHLEEN MILLAR (527), KELLY BURNS (554), MATTHEW STICCA (553), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2014_294555_0029
Log No. / Registre no:	O-001110-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 7, 2015
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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	FRANCIS MARTIS

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) (b)

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 :

The licensee shall prepare, submit and implement a plan to include the following:
- As per LTCHA, 2007 S.O. 2007, c. 8, s. 76 ensure that all staff are educated in the identification of incidents/actions that constitute emotional, verbal, physical, sexual and financial abuse, and neglect of residents, as defined in O. Reg. 79/10 s.2. (1).
- As per LTCHA, 2007 S. O. 2007, c. 8, s. 20 ensure that all staff are educated on the licensee's policy entitled "Resident Abuse – Staff to Resident" and that the policy is complied with.
- As per LTCHA, 2007, S.O. 2007, c. 8, s. 24 ensure all staff are educated on the legislative reporting requirements of all incidents of alleged, suspected or witnessed incidents of abuse or neglect of a resident.
- As per LTCHA, 2007, S.O. 2007, c. 8, s. 23 ensure the licensee shall ensure it investigates immediately of every alleged, suspected or witnessed incident of abuse or neglect of a resident; appropriate actions are taken in response to every incident; and any requirements that are provided for in the regulations for investigating and responding as required are complied with.
- As per O. Reg 79/10 s. 97 ensure all staff are educated on the process of notifying a Resident's Substitute Decision Maker as specified within the legislative requirements.
- As per O. Reg 79/10 s. 99 ensure that an annual evaluation is completed on every incident of alleged, suspected or witnessed abuse or neglect which includes what changes or improvements are requires to prevent further occurrences; the results of the analysis; that the changes and improvements are implemented promptly; and that a written record is prepared including the date of the evaluation, the names of the persons who participated and the date that the changes or improvements were implemented.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.
The plan is to be submitted to Monica Nouri by January 23, 2015 via email to Monica.Nouri@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

- As per LTCHA, 2007 S.O. 2007, c. 8, s. 20 the licensee failed to ensure that the Home's policy entitled "Resident Abuse – Staff to Resident" was complied with (as identified in WN#5).
- As per LTCHA, 2007, S.O. 2007, c.8, s. 23 the licensee failed to ensure that there was an immediate investigation of an alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff; appropriate actions were taken in response to every incident; and any requirements that are provided for in the regulations for investigating and responding as required were complied with. (as identified in WN#6).
- As per LTCHA, 2007, S.O. 2007, c. 8, s. 24 the licensee failed to ensure that the Director was immediately notified when there was an alleged, suspected or witnessed incident of abuse (as identified in WN#7).
- As per LTCHA, 2007, S. O. 2007, c. 8, s. 76 the licensee failed to ensure that all persons receive retraining in Resident Rights, Zero Tolerance of Abuse/Neglect, Duty to Report and Whistle Blowing Protection (as identified in WN #11).
- As per O.Reg 79/10, s. 97 the licensee failed to ensure that the Resident's Substitute Decision Maker was notified within 12 hours of any alleged, suspected or witnessed incident of abuse or neglect (as identified in WN #13).
- As per O. Reg 79/10, s. 99 the licensee failed to ensure that all alleged, suspected or witnessed incidents of abuse or neglect are considered in the annual program evaluation and that the program evaluation is completed (as identified in WN #14). (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 7th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gwen Coles

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