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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 5, 2017	2017_626501_0014	003149-16	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20 and 21, 2017.

Noncompliance under O.Reg (79/10) s. 98 identified in this inspection is being issued in concurrent Critical Incident Inspection 2017_420643_0012.

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 (RNs), Registered Practical Nurses (RPNs), Personal Support Worker (PSWs), resident, Substitute Decision Maker (SDM) and family member.

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed health records, complaint and critical incident record logs, staff training records, staff personnel records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 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. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Review of a complaint and a Critical Incident Report (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 PSW #106 on an identified shift.Resident #002 reported that for the last three identified shifts the PSW had hit him/her.

According to the complaint submitted to the MOHLTC, resident #002 stated that on three identified dates, a PSW came to provide care and appeared to be angry. The PSW first hit the resident on two identified body parts and put an incontinent product on the resident's identified body part. The PSW also hit the resident with the call bell and banged an identified body part onto the hard metal bed rail. According to other notes supplied by the complainant, resident #002 was physically and verbally abused.

Photographs taken by the complainant and sent to the MOHLTC and also shared with the home indicated resident #002 had altered skin integrity to an identified body area. Record review revealed that a skin assessment was completed on an identified date. The assessment indicated that there was altered skin integrity on an identified body area.

The inspector conducted interviews with PSW #106, #127, #128, RPN #131, #109, RN #108 and #129 who all denied having committed or witnessed the alleged abuse.

A review of two assessments conducted on identified dates, indicated the resident's memory was intact and he/she had mild cognitive impairment.

Interviews with resident #002 and his/her SDM revealed that during the above mentioned time period, a PSW got mad and hit him/her. According to the resident, the abuse happened over three days and escalated on the last day. Resident #002 said the PSWs verbally abused him/her as well. Resident #002 also told the inspector that the PSW banged his/her body part on the bed rail. Resident #002 told the inspector that this PSW has worked with him/her again. Further interview with resident #002 revealed the PSW who physically abused him/her was PSW #127. According to the resident, he/she did not know the PSW's name at the time, but does so now, and it was PSW #127.

According to the home's investigation notes, PSW #106 was resident #002's primary care giver during the above mentioned dates. The home interviewed all the PSWs that worked during the night shift on those days except for PSW #127 who was unavailable. According to the home's investigation notes, the home found no grounds for the above alleged abuse. As well, it was documented by the DOC that resident #002 is known to forget and his/her diagnosis has affected his/her cognition. The investigation notes showed poorly detailed interview notes.

Interview with the Administrator repeated similar statements to what the family had documented as having been told, such as PSW #106 would not hit, has no history of abuse and was one of the home's best PSWs. Interview with the current DOC who was not a staff member at the time of the above incident, acknowledged the home did not conduct a proper investigation of the incident and would be reopening the investigation.

The home failed to investigate the allegation of abuse of a resident by anyone, when PSW #127 was not included in the individual interviews. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

Issued on this 8th day of September, 2017

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

Original report signed by the inspector.