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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Feb 27, 2018	2018_642606_0001	000239-18	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

JANET GROUX (606), JULIENNE NGONLOGA (502), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 4, 5, 8, 9, 10, 11, 12, 16, 17, 18, 19, and 22, 2018.

Director's Referral:
HIGH RISK ORDER FOLLOW-UP: Follow-up (FU) to Compliance Order (CO) #001 under inspection report 2017_420643_0011 r. 36 related to safe transferring and positioning devices or techniques when assisting residents.
Follow Up Orders:
FU to CO # 001 s. 5, CO # 002 s. 6 (7), CO # 003 s. 19 (1) related to safe and secure home, plan of care and resident abuse and neglect respectively.
Complaints:
Complaints related to allegations of resident abuse and neglect and related to the management of skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOCs), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Physician, Dietitians, Dietary Manager, Dietary Supervisor, Director of Environmental Services, Physiotherapists (PT), Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Housekeeping, Director of Environmental services (DES), Recreation Aide, Dietary Aides, Receptionist, President of the Resident and Family Councils, Substitute Decision Makers (SDMs), and Residents.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff and resident interactions, observed a resident medication administration, observed infection control staff practices, interviewed the Residents' Council (RC) president, completed a Family Council (FC) questionnaire with the FC president, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2017_420643_0012	606
O.Reg 79/10 s. 36.	CO #001	2017_420643_0011	502
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2017_420643_0012	535

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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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.

On an identified date, while conducting a follow up inspection, the inspector noted that resident #016 was not provided care as specified in the plan of care.

The licensee failed to comply with compliance order #002 from inspection #2017_420643_0012. The licensee was ordered to develop a plan to ensure that the home had a monitoring process to ensure residents received the assistance they require as specified in their plan of care.

The home successfully complied to items #1 and #3 as ordered; but failed to effectively implement item #2 a monitoring process to ensure that resident #016 received the required identified assistance as specified in their plan of care.

Record review revealed resident #016 was assessed by the annual resident assessment instrument minimum data set (RAI-MDS) on an identified date, and the assessment indicated the resident to have an identified medical condition and required an identified intervention. A review of an identified home list indicated the resident was to receive an identified care on an identified date and time.

Record review of the resident's care plan under the identified care focus revealed the resident #016 required identified interventions related to identified medical conditions.

In an interview, the resident's SDM confirmed the resident informed them the resident did not want an identified intervention and preferred another identified intervention for an identified care.

In an interview, PSW #135 indicated resident #016 required an identified care and they had approached resident #016 several times to provide the resident the identified care but resident #016 had refused the identified care from PSW #135. The PSW indicated that after the resident refused the identified care, they then provided the resident an alternate identified care. After reviewing the resident's plan of care, PSW #135 acknowledged that the resident should have received an identified care rather than the care that they provided the resident. PSW #135 stated that they did not review resident #016's plan of care carefully prior to providing care to resident #016.

In an interview, Registered Practical Nurse (RPN) # 110 stated that they were not aware the resident required an identified care and was not aware the information was documented in the resident's written plan of care.

In an interview, Assistant Director of Care A(DOC)#136 indicated that PSW #135 provided an identified care for the resident during an identified time and confirmed that they did not provide care to the resident as specified in the plan of care.

In an interview, the home’s Director of Care (DOC) stated the expectation was that PSW #135 review the resident’s Kardex or plan of care prior to providing care; and sign the document located on each unit which was a requirement in the home. In addition, the DOC confirmed that PSW #135 did not provide care to resident #016 as specified in the plan of care.

Review of a written complaint submitted to the home on an identified date and forwarded to the Ministry of Health and Long Term Care (MOHLTC) indicated an allegation of staff abuse and neglect related to resident #050's care.

Review of a complaint document by resident #050's SDM submitted to the home on an identified date indicated that when they had left the home on an identified date and time, they had left an identified container containing an identified fluid for the resident and that this information was communicated to PSW #131. The SDM indicated that resident #050 informed them that the staff did not give them the identified fluid when they requested it a number of times. The SDM indicated that instead, staff placed the resident in an identified area of the home for a period of time before returning them back to an identified

area of the home.

In an interview, resident #050's SDM indicated resident #050 informed them of what had occurred on the identified date, and that the resident verbalized that the incident had upset them.

The SDM alleged that the staff were abusive and neglectful towards resident #050 on that identified date.

Review of resident #050's progress notes on an identified date indicated resident had been in an identified state since an identified time and requested to engage in an identified ADL. The progress notes indicated the resident was assisted up in a mobility aide and placed in an identified area of the home to prevent the resident from falling. The progress notes indicated that when resident #050 was in an identified state during the identified time and that they will eventually attempt to behave in an identified manner and increase their risk of falling and therefore were put in their mobility aide by an identified location for closer monitoring. The progress notes indicated that resident #050 was given an identified fluid and was then returned back to an identified area of the home at their request.

Review of resident #050's written plan of care revised on an identified date directed staff to provide an identified intervention requested by them.

In an interview, PSW #131, indicated resident #050's SDM left an identified container containing an identified fluid for resident #050 during an identified time to give to the resident when they called during an identified time and indicated they had forgotten to communicate it to the identified staff. The PSW indicated they were not aware that resident #050's plan of care included an identified intervention during an identified time.

In an interview, PSW #144, indicated that resident #050 usually is in an identified state during an identified time but may request an identified intervention from time to time. The PSW indicated that resident's plan of care directed staff to provide an identified intervention if the resident request the identified intervention.

In an interview, Registered Nurse (RN) #132, indicated resident #050 was in an identified state during an identified time and an identified intervention was provided to resident #050 due to an identified care need during the identified time.

The RN indicated they were not aware that resident #050's plan of care included an identified intervention and indicated the resident did not request the identified intervention on the identified date.

In an interview, the DOC indicated that the home completed an investigation and it was noted that staff forgot to communicate to an identified shift that the resident was to be provided an identified intervention during an identified time.

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care was no longer necessary.

Review of a complaint submitted to the home on an identified date and forwarded to the MOHLTC indicated an allegation of abuse and neglect related to resident #050's care. During the inspection, a review of resident #050's progress notes indicated the resident was admitted to the home on an identified date, with identified medical conditions and was identified to be a risk for an identified medical condition.

Further review indicated that on an identified date, the home was informed by resident #050's SDM that resident #050 was in an identified state and observed that the resident did not perform an identified activity of daily living (ADLs) well. Resident #050 was transferred to the hospital during an identified time at the request of the SDM and returned at an identified time, with an identified medical condition.

Review of resident #050's written plan of care revised on an identified date, did not indicate any interventions to manage the resident's risk for developing an identified medical condition.

Further review of resident #050 progress notes on an identified date indicated the resident was in an identified state during identified times. Resident #050 was assessed and was provided an identified intervention and was monitored. At an identified time, resident #050 was witnessed by a PSW to be in an identified state. The resident was transferred to the hospital.

Resident #050 was admitted to the hospital with an identified medical condition and deceased on an identified date.

In an interview, PSW #144, and RN # 132 indicated that they were not aware that resident #050 had a history of developing an identified medical condition and that the plan of care had not provided them any interventions to monitor the resident's risk of developing an identified medical condition.

In an interview, ADOC #141 indicated that the home's practice is that staff must initiate a plan of care to provide interventions to monitor, prevent and manage a resident who has been identified to be a risk for an identified medical condition. The ADOC indicated that there should have been a plan of care for resident #050 after they had been diagnosed with an identified medical condition on an identified date.

3. The licensee has failed to ensure that resident #050 was reassessed and the plan of care reviewed and revised when their care needs changed.

The licensee has failed to ensure that each resident who was incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

As there was a non-compliance related to an identified assessment when an identified care level of a resident had changed, the sample was expanded to three residents.

Review of the resident's #003's RAI-MDS assessment on an identified date revealed that the resident had an identified medical condition and required an identified intervention for an identified care need.

This was a decline from previous RAI-MDS assessment on an identified date, where the resident was identified as being in an identified state.

Review of resident #003's plan of care on an identified date, revealed that they had an identified medical condition and required an identified intervention for an identified care need.

Review of an identified assessment record documented on an identified home record revealed that resident #003's assessment was completed during an identified time and date and they were assessed as being in an identified state related to their care need.

Further review of an identified assessment record failed to identify that an identified assessment was completed when an identified care level had changed on two identified dates.

In an interview, RAI-MDS Coordinator #148, and RPN #147 confirmed that resident #003 identified care level had declined from one identified level to another and that the identified assessment was not completed when the identified care level had changed.

In an interview, ADOC #141 stated that the home's expectation was for registered nursing staff to complete an identified assessment on admission, quarterly and anytime there was a change in the identified care level. They stated that the registered nursing staff on the unit should have completed an identified assessment for resident #003.

Review of a complaint submitted to MOHLTC on an identified date, indicated an allegation of neglect related to an identified skin integrity care need. The complainant reported that after an identified date and time, an identified area of the resident’s body was in an identified state and that after an identified time, an identified area of the resident’s body was in an identified state.

The complainant reported that staff told them that resident #027 had an identified medical condition.

Review of resident's #027's RAI-MDS assessment on an identified date, revealed that resident #003 had identified medical conditions and was assessed to be in an identified state and required an identified device as an intervention to manage the identified care need.

Review of resident #027's progress notes revealed that on an identified date, resident #027's identified device was removed and that the resident was in an identified state.

Review of resident #027's plan of care on an identified date, under an identified care focus revealed that resident #027 had an identified device to manage the identified care need.

Review of the assessment record documented on an identified home record revealed that resident #027's assessment was completed during an identified time and date and they were assessed as being in an identified state with an identified device in place for the identified care need. Further review of the identified assessment record failed to

identify that an identified assessment was completed when the resident's identified care level had changed on two identified dates.

In an interview, RAI-MDS Coordinator #148, and RPN #147 confirmed that resident #027's care level had declined from an identified level to another identified level and that an identified assessment was not completed when the identified care level had changed.

In an interview, ADOC #141 stated that the home's expectation was for registered nursing staff to complete an identified assessment on admission, quarterly and anytime there was a change in identified care level. They stated that the registered nursing staff on the unit should have completed an identified assessment for resident #027.

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On an identified date, while conducting a follow-up inspection, the inspector noted that staff had not used safe transferring techniques when assisting residents #028 and #029.

The home had successfully completed the items identified in CO #001 under inspection report #2017_420643_0011, issued on an identified date that was to be complied by an identified date.

On an identified date and time the inspector observed resident #029 being assisted with

an identified care. The resident was observed in an identified state while being assisted in an identified manner to an identified area of the home. PSW #109 attempted to engage the resident in an identified manner to participate in the identified care care but the resident remained in an identified state and was not able to participate in the identified care care. Both PSWs then placed the resident on an identified transfer equipment, assisted the resident in an identified manner while the resident remained in an identified state and PSW #115 provided an identified care to resident #029 with PSW #10 supported the resident.

Review of resident #029's RAI-MDS revealed that they were identified to have medical conditions that required them to receive identified care interventions.
Review of resident #029's plan of care on an identified date, under an identified ADL care focus indicated the resident required to be provided identified interventions.

In an interview, PSW #109 indicated that they told PSW #115 resident #029 was not able to perform an identified care need and indicated the resident should not be provided the identified care care, but PSW #115 told PSW #109 to provide the identified care while on an identified transfer equipment. PSW #109 stated that they did their best to provide the identified care but indicated that next time they will provide resident #029 the identified care in another identified manner.

In an interview, Physiotherapist (PT) #149 stated that an identified transfer equipment should be used if the resident was alert and only to transfer the resident to assist in the provision of an identified care intervention and not for the identified care that they had provided.

In an interview, PSW #115 stated that they thought the resident was able to participate in the identified care as they indicated the resident had responded in an identified manner. However, PSW #115 indicated they should have have provided an identified care in another manner for resident #029's safety as the resident was in an identified state.

In an interview, RN #156 stated that resident #029 is always in an identified state and will respond in an identified manner to staff but is not able to participate in their care due to an identified condition.

In an interview, ADOC #141 stated that staff were trained to pre-assess the resident and should inform registered staff if the resident was alert prior to providing an identified care. They acknowledged that PSWs #109 and #115 should have provided an identified care

using an identified care equipment and provided care in an identified manner rather than the identified care that they had provided the resident.

In an interview DOC #101 stated that the home's expectation was that staff assessed the resident prior to providing an identified care and if the resident was in an identified state, staff should provide the care in another identified manner. They acknowledged that using an identified care equipment while the resident was in an identified state was not a safe way to provide an identified care.

On an identified date and time, the inspector observed PSWs #111 and #162 assisting resident #028 with an identified care using an identified transfer equipment. The resident was observed in the identified transfer equipment and was transferred in an identified manner to an identified an area and provided an identified care while the resident was in an identified state on the identified care equipment.

Review of resident #028's plan of care, under an identified care focus indicated that resident #028 required an identified intervention due to identified medical conditions. The plan of care directed staff to provide an identified intervention to resident #028 using an identified care equipment.

Review of an identified home program education module provided to the staff in the home indicated that prior to using an identified care equipment, staff should assessed that the resident is in an identified state and ready to participate in the identified care.

In an interview, PSW #162 stated that an identified care equipment was used only if the resident was able to participate in the identified care. PSW #162 stated that they were not aware that resident #028 was not able to participate in the identified care. They indicated that the resident was provided an identified care safely because they had supported them.

In an interview, PSW #111 stated that they were aware that resident #028 usually participated in the identified care, however, they indicated that the resident had been observed to move their identified body parts in an identified manner while being provided care that they should have reported this observation to to PT.

In an interview, ADOC #141 stated that staff were trained to pre-assess the resident and inform registered staff if the resident was not alert to use an identified care equipment. They acknowledged that PSWs #109 and #115 should have transferred resident #028

with an identified care equipment and provided the identified care in an identified manner.

In an interview, DOC #101 stated that the home's expectation was that staff assessed the resident prior to each transfer and if the resident was not alert, then staff should have provided care in an identified manner.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On an identified date, a complaint was submitted to the MOHLTC related to a complaint about an identified care need. The complainant reported that after an identified date and time, the resident had an identified skin integrity impairment and after an identified time and date the resident was in an identified skin integrity impairment. After an identified period of time, resident #027's skin integrity impairment was in an identified state. The complainant reported that staff told them that resident #027 had an identified skin integrity impairment.

Review of the resident's #027's RAI-MDS assessment on an identified date, revealed

that resident #003 had identified medical conditions.

Review of the progress note revealed on an identified date, registered nursing staff documented that resident #027 was noted to have an identified skin integrity impairment after after an identified care was provided.
-On an identified date, registered nursing staff documented that the resident had an identified skin integrity impairment to identified areas of their body and an identified treatment was applied and that staff were to monitor.
-On an identified date, nursing staff completed an identified assessment and documented that resident had an identified skin integrity, and was in an identified state.
-On an identified date, resident #027's SDM called DOC #101 to express a concern regarding the resident's identified skin integrity impairment.

Further review of resident #027's progress notes indicated that the DOC documented that the SDM wanted the resident to be sent to the hospital as the identified skin integrity impairment was in an identified state. DOC #101 referred resident #027 to the NP. Upon assessment the NP documented that resident #027 had an identified skin integrity impairment and was in an identified state.

Review of the assessment record documented on PCC failed to reveal a completed skin assessment by a member of the registered nursing staff from an identified date, when the identified skin integrity impairment was identified on an identified date when the resident was transferred to the hospital.

In an interview, RPN #152 and RN #156 confirmed that resident #027 identified skin integrity impairment was noted on an identified date and had progressed to an identified skin integrity impairment on an identified date and that they had not assessed the resident, as it was an oversight.

In an interview, DOC #101 stated that the home's expectation was for registered nursing staff to complete an identified assessment for any impaired skin integrity including an identified skin integrity impairment using a clinically appropriate assessment instrument available on PCC, and acknowledged that resident #027 should have been assessed by the registered staff on the unit.

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made

to the plan of care related to nutrition and hydration been implemented.

On an identified date, a complaint was submitted to the MOHLTC related to a complaint about an identified care need. The complainant reported that after an identified date and time, the resident had an identified skin integrity impairment and after an identified time and date the resident was in an identified skin integrity impairment. Three weeks after admission resident #027's skin turned black. The complainant reported that staff told them that resident #027 had an identified skin integrity impairment.

Review of the resident's #027's RAI-MDS assessment on an identified date, revealed that resident #003 had identified medical conditions.

Review of the progress note revealed on an identified date, registered nursing staff documented that resident #027 was noted to have an identified skin integrity impairment after after an identified care was provided.
-On an identified date, registered nursing staff documented that the resident had an identified skin integrity impairment to identified areas of their body and an identified treatment was applied and that staff were to monitor.
-On an identified date, nursing staff completed an identified assessment and documented that resident had an identified skin integrity, and was in an identified state.
-On an identified date, resident #027's SDM called DOC #101 to express a concern regarding the resident's identified skin integrity impairment.
Further review of resident #027's progress notes indicated that the DOC documented that the SDM wanted the resident to be sent to the hospital as the identified skin integrity impairment was in an identified state. DOC #101 referred resident #027 to the NP. Upon assessment the NP documented that resident #027 had an identified skin integrity impairment and was in an identified state.

In an interview, RD #122, #139, and #140 stated of being aware that resident #027 had been identified to be at risk for nutritional intake and that an identified assessment had not been completed after the nurse sent the initial referral to the dietary department, as they had not communicated to each other to ensure that one of the RDs had completed the identified assessment.

In an interview, DOC #101 stated that the home's expectation was that one of the home's three RDs should have assessed resident #027 when a referral was sent related to an identified skin integrity impairment.

3. The licensee has failed to ensure that the resident who was dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

On an identified date, a complaint was submitted to the MOHLTC related to a complaint about an identified care. The complainant alleged that when they visited the resident, no staff came in for an identified time period to provide an identified care intervention due to an identified home issue.

Review of the resident's #027's RAI-MDS assessment on an identified date, revealed that resident #003 had identified medical conditions that required identified care interventions.

Review of the progress notes revealed that on an identified date, registered nursing staff documented that resident #027 was noted to have an identified skin integrity impairment to an identified area of the resident’s body after an identified care had been provided. The progress notes further indicated that an identified assessment was completed, and that an identified care intervention was provided and an identified treatment was applied, and that a referral was sent to the RD, PT and the Skin Wound Champion.

On an identified date, PT #149 assessed resident #027 for an identified skin integrity impairment to an identified area of the resident’s body and noted an identified intervention provided to the resident had been discontinued with a reported identified medical condition and treatment. PT #149 had put a new mobility aide in place and identified interventions and directed staff to provide an identified care intervention for an identified time period when the with additional identified care provisions related to an identified care need.

On an identified date, resident #027's SDM called DOC #101 to express a concern regarding the resident’s identified skin integrity impairment. The DOC documented that the SDM wanted the resident to be sent to the hospital as the skin integrity impairment was in an identified state. DOC #101 assessed resident #027's identified skin integrity impairment to be in an identified state and that the resident had an identified nutritional intake and was being treated for an identified medical condition, and they had referred the resident to the NP for further assessment.

Review of resident #027's plan of care revealed an identified intervention was not

identified as a task to be completed by the PSWs.

Review of resident #027's identified intervention report for an identified time, copied from an identified home documentation system revealed no documentation that resident was provided an identified intervention during an identified time period.

In an interview, PSWs #150, #154 and #163 stated they did not remember providing an identified intervention for resident #027 as the task was not identified in the POC and Kardex.

In an interview, RN #156 indicated that for a resident who required to be provided an identified intervention, a task would be added in the plan of care and the Kardex for PSWs provide the identified intervention and document in the POC. RN #156 acknowledged that resident #027 was not consistently provided the identified intervention for an identified period of time.

In an Interview, ADOC #157, indicated that an identified intervention was one of the home's initial interventions when a resident has been identified with an altered skin integrity to an identified area of their body, and it would be added as a task to the Kardex and POC for the PSWs to complete at each shift. ADOC #157 acknowledged that resident #027 should have been provided an identified intervention for an identified time period when an identified skin integrity impairment were identified to an identified area of the resident's body.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, 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,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to have his/her personal health information (within the meaning of Personal Health Information Protection Act, 2004) kept confidential, and access to his or her records of personal health information, including his/her plan of care, in accordance with the Act.

On an identified date, the inspector observed the medication pass and observed that registered staff RN #110 had discarded resident #014 and #015's medication pouches after removing the medication, in an identified location.

During an interview, RN #110 stated that normally registered staff put all empty medication pouches in an identified location and at the end of the shift, the staff perform an identified procedure to remove all residents' personal health information before discarding the blank pouches in the garbage. RN #110 confirmed discarding both residents' empty medication pouches in the garbage and stated that they should not have been thrown in the garbage until their personal health information were removed.

In an interview, the home's DOC stated that the empty medication pouches should not have been discarded in the garbage until the residents' personal health information were removed and confirmed that the registered staff failed to ensure that both residents' personal health information were kept confidential.

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 the resident’s right to have his/her personal health information (with the meaning of Personal Health Information Protection Act, 2004) kept confidential, and access to his or her records of personal health information, including his/her plan of care, in accordance with the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The home failed to ensure that the following rules are complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to was, i. kept closed and locked.

During the initial tour of the home on an identified date, the inspector observed on the an identified area of the home, a half barrier door at the top of a stairwell that lead down to an unlocked doorway which lead to non-residential areas of the home was easily opened by pushing a button on a latch located on the top half of the barrier door. The inspector observed that the barrier door was secured in place with a push button latch located on the top half of the barrier door. The inspector tested that the push button latch was easily reachable by anyone standing beside the half barrier door. The inspector noted also two elevators were situated across this stairwell and had observed during this observation and throughout the RQI that residents from identified areas of the home as well as staff, visitors, and families used the elevators to access an identified area of the home.

The inspector observed during the RQI that several residents used an identified area of

the home for an identified ADL.

In an interview with PSW #160 and #161, they indicated that an identified agency had used the stairs leading down to the lower level to access their agency but the identified agency no longer uses the stairs.They indicated that they do not use the stairs to access the lower level but have witnessed others using it to get down to the lower level.They indicated the latch that keeps the half barrier door secured would be accessible to a resident who may happen to come over and open the barrier door.

In an interview with the ED, they indicated that the stairs leading to the lower level is used from time to time by the maintenance staff. They indicated that the identified area is monitored via an identified device located at an identified area of the home and is not monitored on an ongoing basis. They further indicated that it is possible for a resident to access and release the half barrier door.

The home failed to ensure that the following rules are complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to was i. kept closed and locked.

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home completed a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition and assessed the resident's nutritional status, including any risks related to nutrition care, and hydration status, and any risks related to hydration.

Review of a complaint submitted to MOHLTC on an identified date, indicated an allegation of neglect related to nutrition and dehydration. The complainant expressed concerns that the resident had not been assessed by the RD for three identified medical conditions. The complainant stated that resident was supposed to receive an identified fluid for an identified period of time. And that the complainant stated that the resident alleged that when they indicate they want an identified fluid, they do not receive it.

Review of resident #027's RAI-MDS assessment on an identified date, revealed that resident #027 was admitted to the home on an identified date, and was identified with several medical conditions.

Review of an identified assessment documented in PCC completed on an identified date by RD #139 revealed the resident's nutritional intake was stable during an identified time period and indicated the resident's nutritional intake was in an identified stated related to identified care factors.

Further review revealed an identified resident #027 to be at risk for nutrition due to identified medical, physical and psychological conditions.

The RD's assessment failed to identify resident #027's daily nutritional requirements.

Review of the resident's nutritional intake for an identified time period, revealed that resident #027's identified nutritional intakes during identified meal times and during several identified time periods were in an identified state due to identified factors.

Review of an identified assessment documented in PCC completed on an identified date, by RD #139 revealed that they failed to identify a determination of the resident's nutritional risk and failed to address the resident’s identified nutritional requirements.

In an interview, RD #139 stated the initial nutritional assessment included a conversation with the resident's SDM and a review of an identified nutritional record of the resident.The RD further stated the assessment did not include an observation of the resident during meal times.

In an interview on an identified date, RD #122 calculated resident #027's identified nutritional at an identified level.

In an interview, RD #122 stated that the home's expectation in completing an identified assessment was to include an observation of the resident during meal time, review of the intake record from the admission date to the assessment date, and review of any available identified labratory values. RD #122 acknowledged that RD #139 should have identified the resident's the nutritional risk related to their declined of an identified nutritional need during an assessment and included interventions in the plan of care.

Review of the progress notes revealed an identified number of time periods that the resident was identified to be at a nutritional risk and in an identified medical state.
-on an identified date, the resident’s identified intake and output was at an identified level.
-on an identified date, according to RD #139 documentation a PSW reported to them that the resident was in an identified state during an identified period of time
-on an identified date, the resident's identified nutritional intake and output was at an identified level.
-on an identified date, the resident was in a medical state during an identified meal service.
-on an identified date, the resident's fluid intake was at an identified level, which was less than the daily requirement.
-on an identified date, the resident was in an identified state during identified times.
-on an identified date and time resident #027's SDM complained to ADOC #136 that the

resident had been in an identified state for an identified period of time and that the resident was observed to be in an identified condition. The ADOC endorsed the nutrition concern to the home's registered dietitian.
-On an identified date and time RD #122 called the resident's SDM related to their concern of ongoing poor intake. According to RD #122's documentation the poor intake might be related to resident's identified medical state and that they will follow up.

The inspector had not identified a dietitian's follow up during review of the resident's health record.
-On three identified dates, the resident's fluid intake was at an identified levels respectively.
-on an identified date, resident #027's was assessed with an identified skin integrity impairment on an identified area of their body and DOC #101 documented that resident #027 had been in an identified state.
-on an identified date and time, registered nursing staff documented that the resident had not meet the identified nutritional target and was identified with sign of an identified medical condition that included an identified medical condition.
-on an identified date, the resident was transferred to the hospital and diagnosed with an identified medical condition and subsequently passed on an identified date.

Review of the assessment record in PCC had not identified a completed nutrition assessment when the resident condition had changed as demonstrated through an identified medical condition and identified nutritional state.

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 registered dietitian who is a member of the staff of the home (a) complete a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition, (b) assess the resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and dietary services programs included height upon admission and annually thereafter.

During the Resident Quality Inspection (RQI) stage one abaqis census record reviews, residents' #021, #022, #023, #024, #225, and #026 heights were last obtained in 2016 and not after.

In an Interview, RN ##127 and ADOC #141 indicated the home's practice was to obtain a resident's height on an annual basis and were not sure why the heights for the above mentioned residents were not obtained.

The licensee failed to ensure that the nutrition care and dietary services programs included height upon admission and annually thereafter for residents' #021, #022, #023, #024, #225, and #026. [s. 68. (2) (e) (ii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

On an identified date, the inspector reviewed an identified home document and noted that only one review was completed on an identified date and time and that document did not have an associated name or signature indicating who completed the review.

In an interview and review of the document, Director of Care #102 confirmed that the interdisciplinary team met and reviewed all four quarters of the home's medication incidents and adverse drug reactions in an identified date and therefore, the team did not meet on a quarterly basis to review the medication incidents and adverse drug reactions as required by the MOHLTC.

Issued on this 28th day of February, 2018

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET GROUX (606), JULIENNE NGONLOGA (502), VERON ASH (535)
Inspection No. / No de l'inspection :	2018_642606_0001
Log No. / No de registre :	000239-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 27, 2018
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:

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_420643_0012, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 8, s 6(7) to ensure the care set out in the plan of care is provided to resident #016 and any other resident as specified in the plan of care.

Grounds / Motifs :

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.

On an identified date, while conducting a follow up inspection, the inspector noted that resident #016 was not provided care as specified in the plan of care.

The licensee failed to comply with compliance order #002 from inspection #2017_420643_0012. The licensee was ordered to develop a plan to ensure that the home had a monitoring process to ensure residents received the assistance they require as specified in their plan of care.

The home successfully complied to items #1 and #3 as ordered; but failed to effectively implement item #2 a monitoring process to ensure that resident #016 received the required identified assistance as specified in their plan of care.

Record review revealed resident #016 was assessed by the annual resident assessment instrument minimum data set (RAI-MDS) on an identified date, to have an identified medical condition and required an identified intervention. A review of an identified home list indicated the resident was to receive an identified care on an identified date and time.

Record review of the resident's care plan under the identified care focus revealed the resident #016 required identified interventions related to identified medical conditions.

In an interview, the resident's SDM confirmed the resident informed them the resident did not want an identified intervention and preferred another identified intervention for an identified care.

In an interview, PSW #135 indicated resident #016 required an identified care and they had approached resident #016 several times to provide the resident the identified care but resident #016 had refused. The PSW indicated that after the resident refused the identified care, they then provided the resident an alternate identified care. After reviewing the resident's plan of care, PSW #135 acknowledged that the resident should have received an identified care. PSW #135 stated that they did not review resident #016's plan of care carefully prior to providing care to resident #016.

In an interview, Registered Practical Nurse (RPN) # 110 stated that they were not aware the resident required an identified care and was not aware the information was documented in the resident's written plan of care.

In an interview, Assistant Director of Care A(DOC) #136 indicated that PSW #135 provided an identified care for the resident during an identified time and confirmed that they did not provide care to the resident as specified in the plan of care.

In an interview, the home's Director of Care (DOC) stated the expectation was that PSW #135 review the resident's Kardex or plan of care prior to providing care; and sign the document located on each unit which was a requirement in the home. In addition, the DOC confirmed that PSW #135 did not provide care to resident #016 as specified in the plan of care.

The severity is 3 – Actual Harm/Risk
The scope is 2- patterned.
The home's compliance history is 4-with an Order (CO).
(535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2018

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s.36. Specifically, the licensee will ensure staff use safe transferring and positioning devices or techniques when assisting residents #028 and #029; and any other resident requiring transfer with a mechanical lifting device.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On an identified date, while conducting a follow-up inspection, the inspector noted that staff had not used safe transferring techniques when assisting residents #028 and #029.

The home had successfully completed the items identified in CO #001 under inspection report #2017_420643_0011, issued on an identified date that was to be complied by an identified date.

On an identified date and time, the inspector observed PSWs #111 and #162 assisting resident #028 with an identified care using an identified transfer equipment. The resident was observed in the identified transfer equipment and was transferred in an identified manner to an identified an area and provided care while the resident was in an identified state on the identified care equipment.

Review of resident #028's plan of care, under an identified care focus indicated that resident #028 required an identified intervention due to identified medical conditions. The plan of care directed staff to provide an identified intervention to

resident #028 using an identified care equipment.

Review of an identified home program education module provided to the staff in the home indicated that prior to using an identified care equipment, staff should assessed that the resident is in an identified state and ready to participate in the identified care.

In an interview, PSW #162 stated that an identified care equipment was used only if the resident was able to participate in the idenified care. PSW #162 stated that they were not aware that resident #028 was not able to participate in the identified care. They indicated that the resident was provided an identified care safely because they had supported them.

In an interview, PSW #111 stated that they were aware that resident #028 usually participated in the identified care, however, they indicated that the resident had been observed to move their identified body parts in an identified manner while being provided care that they should have reported this observation to to PT.

In an interview, ADOC #141 stated that staff were trained to pre-assess the resident and inform registered staff if the resident was not alert to use an identified care equipment. They acknowledged that PSWs #109 and #115 should have transferred resident #028 with an identified care equipment and provided the identified care in an identified manner.

In an interview, DOC #101 stated that the home's expectation was that staff assessed the resident prior to each transfer and if the resident was not alert, then staff should have provided care in an identified manner.

2. On an identified date and time the inspector observed resident #029 being assisted with an identified care. The resident was observed in an identified state while being assisted in an identified manner to an identified area of the home. PSW #109 attempted to engage the resident in an identified manner to participate in the identified care care but the resident remained in an identified state and was not able to participate in the identified care care. Both PSWs then placed the resident on an identified transfer equipment, assisted the resident in an identified manner while the resident remained in an identified state and PSW #115 provided an identified care to resident #029 with PSW #10 supported the resident.

Review of resident #029's RAI-MDS revealed that they were identified to have medical conditions that required them to receive identified care interventions. Review of resident #029's plan of care on an identified date, under an identified ADL care focus indicated the resident required to be provided identified interventions.

In an interview, PSW #109 indicated that they told PSW #115 resident #029 was not able to perform an identified care need and indicated the resident should not be provided the identified care care, but PSW #115 told PSW #109 to provide the identified care while on an identified transfer equipment. PSW #109 stated that they did their best to provide the identified care but indicated that next time they will provide resident #029 the identified care in another identified manner.

In an interview, Physiotherapist (PT) #149 stated that an identified transfer equipment should be used if the resident was alert and only to transfer the resident to assist in the provision of an identified care intervention and not for the identified care that they had provided.

In an interview, PSW #115 stated that they thought the resident was able to participate in the identified care as they indicated the resident had responded in an identified manner. However, PSW #115 indicated they should have have provided an identified care in another manner for resident #029's safety as the resident was in an identified state.

In an interview, RN #156 stated that resident #029 is always in an identified state and will respond in an identified manner to staff but is not able to participate in their care due to an identified physical condition.

In an interview, ADOC #141 stated that staff were trained to pre-assess the resident and should inform registered staff if the resident was alert prior to providing an identified care. They acknowledged that PSWs #109 and #115 should have provided an identified care using an identified care equipment and provided care in an identified manner.

In an interview DOC #101 stated that the home's expectation was that staff assessed the resident prior to providing an identified care and if the resident was in an identified state, staff should provide the care in another identified manner. They acknowledged that using an identified care equipment while the resident was in an identified state was not a safe way to provide an identified care.

The severity of this issue was a level 2 as there was potential for actual harm to the residents. The scope was level 2 as two of four residents observed had not been transferred using safe transferring techniques.
Compliance history was a level 4 as there was related compliance orders and a previous Director Referral with this section of the LTCHA which included:
- Compliance order #2016_302600_0001 issued February 8, 2016,
- Compliance order #2016_430644_0012 issued February 7, 2017,
- Compliance order #2017_420643_0011 issued July 12, 2017, and
- Director Referral #2017-420643_0011 issued July 12, 2017.

Based on the home's compliance history with section r.36, a Director's Referral has been issued.

(502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2018

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50. (2) specifically, the licensee will ensure any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
- receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
- is assessed by a registered dietitian who is a member of the staff of the home, and any
changes made to the resident's plan of care relating to nutrition and hydration are implemented, and any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On an identified date, a complaint was submitted to the MOHLTC related to a complaint about an identified care need. The complainant reported that after an identified date and time, the resident had an identified skin integrity impairment and after an identified time and date the resident was in an identified skin integrity impairment. After an identified period of time, resident #027's skin integrity impairment was in an identified state. The complainant reported that staff told them that resident #027 had an identified skin integrity impairment.

Review of the resident's #027's RAI-MDS assessment on an identified date, revealed that the resident had identified medical conditions.

Review of the progress note revealed on an identified date, registered nursing staff documented that resident #027 was noted to have an identified skin integrity impairment after after an identified care was provided.
-On an identified date, registered nursing staff documented that the resident had an identified skin integrity impairment to identified areas of their body and an identified treatment was applied and that staff were to monitor.
-On an identified date, nursing staff completed an identified assessment and

documented that resident had an identified skin integrity, with was in an identified state.
-On an identified date, resident #027's SDM called DOC #101 to express a concern regarding the resident's identified skin integrity impairment.

Further review of resident #027's progress notes indicated that the DOC documented that the SDM wanted the resident to be sent to the hospital as the identified skin integrity impairment was in an identified state. DOC #101 referred resident #027 to the NP. Upon assessment the NP documented that resident #027 had an identified skin integrity impairment and was in an identified state.

Review of the assessment record documented on PCC failed to reveal a completed skin assessment by a member of the registered nursing staff from an identified date, when the identified skin integrity impairment was identified on an identified date when the resident was transferred to the hospital.

In an interview, RPN #152 and RN #156 confirmed that resident #027 identified skin integrity impairment was noted on an identified date and had progressed to an identified skin integrity impairment on an identified date and that they had not assessed the resident, as it was an oversight.

In an interview, DOC #101 stated that the home's expectation was for registered nursing staff to complete an identified assessment for any impaired skin integrity including an identified skin integrity impairment using a clinically appropriate assessment instrument available on PCC, and acknowledged that resident #027 should have been assessed by the registered staff on the unit.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

The severity is 3 – Actual Harm/Risk
The scope is 1- isolated.
The home's compliance history is 2-1 or more unrelated NC in last 3 years.
(502)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector / Nom de l'inspecteur : Janet Groux

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