Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 4, 2020 | 2020_718751_0006 | 003047-20 | Critical Incident System |

### Licensee/Titulaire de permis

Tendercare Nursing Homes Limited
20 High Park Blvd. TORONTO ON M6R 1M7

### 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

ASAL FOULADGAR (751), AMANDEEP BHELA (746)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): July 24, 28, 29, 30, 31, 2020**

**During this inspection the following critical incident system (CIS) report was inspected:**
**One Log related to the prevention of abuse and neglect a resident.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOCs), and personal support worker(s) (PSW).**

**During the course of the inspection, the inspectors(s) reviewed health records, the home's investigation 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)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with in regards to conducting a full investigation into allegation of staff to resident verbal abuse.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report on an identified date, indicating allegations of verbal abuse by Personal Support Worker (PSW) #100 toward resident #001. According to the CIS Report, resident #001's family member reported to the home that PSW #100 was verbally rough and inappropriate with the resident and the allegations were confirmed by resident #002 who was resident #001's roommate.

A review of resident #001's electronic clinical records indicated that they were discharged form the home prior to the initiation of this inspection. Further review of the resident's health record indicated they had borderline intact cognition and required assistance from staff to complete certain activities of their daily living due to an identified medical diagnosis.

A review of resident #002's electronic clinical records who was identified as the witness to the above-mentioned allegations of verbal abuse, indicated they were discharged form the home prior to the initiation of this inspection. Further review of the resident's health records indicated they had intact cognition.

A review of the home's investigation notes indicated as per resident #001's family member, PSW #100 was "rough" and "inappropriate" with them. Further review of the home's investigation notes one day after the reported incident indicated that PSW #100 denied all the allegations of verbal abuse. Review of the home's investigation notes, did not present evidence of further detailed interview with resident #001 and/or resident #002. The home concluded that the allegations of verbal abuse by PSW #100 towards resident #001 were substantiated and issued a discipline letter to PSW #100.

Inspector #647 and #751 were unable to conduct an interview with residents #001 and #002 as both residents had been discharged from the home at the time of this inspection.

In an interview with PSW #100, they denied the above-mentioned allegations and provided an explanation as to what had occurred during their interaction with resident #001. PSW #100 added that they had stated the same explanation during the home's investigation process.

Inspector #751 reviewed the home's policy #RC 02-01-03, titled "Zero Tolerance of Resident Abuse and Neglect", last updated in June 2019. According to "Appendix 2" of the above-mentioned policy, titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences", interview the witness and collect witness statement was required as part of the investigation process.

In an interview, Assistant Director of  Care (ADOC) #102 confirmed that they did not interview resident #002 whom they identified as witness in the CIS report. ADOC #102 indicated, at the time they were receiving information about the allegations of verbal abuse, resident #002 who was present in the room, replied to resident #001's family member in response to their question if PSW #100 was "loud". ADOC #102 stated they did not carry out a separate interview with resident #002 to obtain further details. ADOC #102 acknowledged that interviewing the witness and collecting witness statement is part of the home's investigation policy of zero tolerance of resident abuse and neglect.

In a separate interview with ADOC #101, they indicated that they only interviewed PSW #100 during their investigation process. ADOC #101 confirmed that they did not carry out separate interviews with residents #001 and #002 and they concluded their investigation based on verbal report from ADOC #102 and the documentations in the CIS report.

In an interview with Director of Care (DOC) #103, the outcome of inspector's interviews with ADOC #101, ADOC#102, and PSW #100 were discussed and the home's investigation notes were reviewed. DOC #103 acknowledged that due to lack of concrete information gathered through this investigation process, the allegations of verbal abuse could not be concluded as a result of this inspection. DOC #103 also confirmed that the home failed to follow the home's zero tolerance of resident abuse and neglect in terms of conducting a full investigation including interviewing resident #002 who was identified as witness into this allegation of verbal abuse.

**Issued on this 6th day of August, 2020**

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

**Original report signed by the inspector.**