Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: October 3, 2024	
Inspection Number: 2024-1157-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Tendercare Nursing Homes Limited	
Long Term Care Home and City: Tendercare Living Centre, Scarborough	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s) The Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 16-20, 23-26, 2024.

The following intakes were inspected in this complaint inspection:

- One intake related to a complaint with concerns with medication administration, improper care, and documentation.
- One intake related to a complaint with concerns of improper care of a resident.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Three intakes related to allegations of staff to resident abuse.
- One intake related to a medication error.
- Two intakes related to allegations of improper care of a resident.

- One intake related to an outbreak of disease of public significance.
- One intake related to a fall with injury.

The following intakes were completed in this inspection:

- One intake related to a fall with injury.
- One intake related to a complaint with concerns with safety and privacy and the displacement of residents.
- One intake related to allegations of improper care of a resident.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected by a nursing staff.

Ontario Regulation 246/22, s. 7 states that "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

A Critical Incident Report (CIR) concerning a medication incident involving a resident was submitted by the Long-Term Care Home (LTCH). The Ministry of Long-Term Care (MLTC) received a corresponding complaint related to the same incident.

The resident was to receive a medication as part of their treatment plan. A nursing staff administered the medication at the end of their shift but did not document that the resident received the medication. A different nursing staff administered the same medication approximately one hour later.

The medication incident was identified by two nursing staff immediately after the drug was administered. The nursing staff reported that they assessed the resident and notified the physician and the resident's family. This occurred approximately an hour and a half after the incident was first discovered. The same nursing staff documented later in the shift that they reassessed the resident.

The home's investigation discovered that the nursing staff did not complete a reassessment of the resident and they falsified the resident's record. The nursing staff admitted to not monitoring the resident throughout their shift after the incident and documented false values.

The Assistant Director of Care (ADOC) and the interim Director of Care (DOC) acknowledged the nursing staff neglected the resident when they did not complete a reassessment of the resident after the incident and falsified documentation.

The resident's well-being was jeopardized when the nursing staff neglected to

assess and monitor the resident after a medication incident.

Sources: A resident's clinical record, the home's investigation notes, interviews with registered staff and the interim DOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A CIR was submitted to the Director alleging the resident was hit by a nursing staff.

A review of the resident's electronic chart indicated that the resident had informed a visitor that they were hit by a nursing staff and the visitor had requested a complaint form to be completed. After the visitor had left, the staff then began the investigation and concluded that the allegation was unfounded.

As per the home's policy on zero tolerance of resident abuse and neglect program, any employee who became aware of an alleged resident abuse was to immediately report the matter to their reporting manager or the most senior supervisor on shift at that time.

When interviewed, the identified registered staff understood that any allegation of resident abuse was to be immediately reported to their Assistant Director of Care (ADOC) but stated there was no evidence to support the abuse had occurred. The staff, therefore, did not report the matter to their supervisor.

The interim Director of Care (DOC) asserted that the registered staff was expected to immediately report to their manager once they became aware of the allegation.

There was a potential risk of harm to the resident as the allegation might impact their quality of life and delaying the home in implementing the appropriate support for the resident.

Sources: Resident's electronic charting, home's policy on zero tolerance of resident abuse and neglect program, and interviews with the registered staff and the interim DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure the Director was immediately reported when the resident was suspected to have been neglected by the staff.

Rationale and Summary

A CIR was submitted to the Director alleging the resident was neglected by the nursing staff of a required personal care.

As per the home's internal investigative notes, the resident was found to be soaked with body substances during an afternoon. The matter was reported to the evening ADOC the same shift. However, the Director was not contacted about the allegation until few weeks later, when the evening ADOC returned to work from their absences.
When interviewed, the day ADOC asserted that the evening ADOC should have immediately contacted the Director when they first became aware of the allegation.

There was a potential risk of harm to the resident as the home might not have implemented the most appropriate care interventions to better support the resident and their care.

Sources: Home's internal investigative notes, and staff interview with the day ADOC.

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to ensure that two direct care staff who had received training under subsection (2), receive retraining in the areas mentioned in that subsection on an annual basis, specifically, continence care and bowel management.

Rationale and Summary

A CIR was submitted to the Director alleging the resident was neglected by the nursing staff of a required personal care.

A review of the 2023 training records indicated that two direct care staff did not complete the continence care and bowel management training until 2024. Further review of the staffing records indicated that both employees had worked multiple shifts in December 2023.

When interviewed, the ADOC confirmed that both staff should have completed the identified training by December 2023.

There was a potential risk and impact to the residents as the direct care staff might not have provided the residents with continence care and bowel management that were based on the 2023 training materials.

Sources: The 2023 training records, staffing records, and interview with the ADOC.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that the resident who was unable to toilet independently, some or all of the time, received assistance from staff to manage and maintain continence.

Rationale and Summary

A CIR was submitted to the Director alleging the resident was neglected by the nursing staff of a required personal care.

A review of the resident's electronic care plan indicated that they required staff assistance with their toileting due to their medical condition. In addition, the resident was to be checked every two hours if they required to be toileted.

As per the home's investigative notes, a Personal Support Worker (PSW) was assigned to provide care to the resident during their shift. While continence care was provided to the resident prior to lunch time, no continence care or checks were provided to the resident from after lunch to the end of the shift. Continence care was only provided to the resident at the beginning of the next shift.

When interviewed, the PSW stated they had forgotten to check on the resident after lunch as the staff was providing care to other residents under their care. The ADOC asserted that the nursing staff was required to check the resident every two hours for their toileting needs as per their electronic care plan.

There was a risk and impact to the resident as the resident did not receive the required continence care and might have negatively impacted their quality of life.

Sources: The resident's electronic health records, home's internal investigative notes, and staff interviews with the PSW and ADOC.

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition,

dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

1. The licensee has failed to ensure that a nursing staff adhered to the written policies and protocols for the medication management system to ensure the accurate administration of all drugs used in the home.

In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee is required to ensure the medication management program is complied with. Specifically, a nurse did not follow the High-Alert Medications policy to complete an independent double check of work prior to administering a high-alert drug.

Rationale and Summary
A CIR regarding a medication incident involving a resident was submitted by the LTCH. The MLTC received a corresponding complaint related to the same incident.

There was an incident involving a resident and a high-alert medication. The LTCH's policy on high-alert medications requires an independent double check by two nurses. Each nurse is expected to ensure all steps are followed to safely prepare the medication, including verifying the eight rights: right resident, drug, dose, time, route, reason, response, and documentation. Further, the first nurse must not communicate their expectations to the second nurse.

The nursing staff prepared the high-alert medication for a resident and sought a second nursing staff for a second check. The nursing staff instructed the second nursing staff to verify the dose without specifying the resident. The nursing staff completing the second check later realized that the medication had already been administered earlier by the previous shift nursing staff, resulting in the resident receiving two doses.

Several staff members, including the ADOC and the interim DOC, confirmed that an independent second check by two nurses is required for high-alert medications. ADOC acknowledged that the staff did not perform a proper independent second check for the resident.

The failure of the nursing staff to complete a proper independent second check when administering a high-alert drug put the resident at risk of an overdose.

Sources: A resident's clinical record, the home's investigation notes, LTCH policy Medication Management, interviews with nursing staff and others.

2. The licensee has failed to ensure that a nursing staff adhered to the written policies and protocols for the medication management system to ensure the accurate administration of all drugs used in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the medication management program is complied with. Specifically, the nursing staff did not follow the Medication Management policy to ensure documentation has been completed upon completion of the medication pass.

Rationale and Summary
A CIR regarding a medication incident involving a resident was submitted by the LTCH. The MLTC received a corresponding complaint related to the same incident.

There was a medication incident involving a resident and a high-alert medication. The LTCH's policy on medication management requires nurses to ensure that all residents have been given their medication and the documentation has been completed at the end of the medication pass. The nursing staff administered a

medication to a resident at the end of their shift but did not complete the documentation. The medication order remained present as unadministered. Another nursing staff administered the same order of the medication to a resident approximately an hour later.

The nursing staff could not recall if they signed the documentation after administration, but they acknowledged that this is a requirement of medication administration. The nursing staff reported that they gave a resident the second dose of medication because the documentation was not completed.

The resident was at risk of an overdose when the nursing staff failed to document the administration of the medication.

Sources: A resident's clinical record, LTCH's investigation notes, LTCH policy High-Alert Medications, interviews with nursing staff, ADOC and others.

3. The licensee has failed to ensure that the nursing staff adhered to the written policies and protocols for the medication management system to ensure the accurate storage and administration of all drugs used in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the medication management program is complied with. Specifically, the nursing staff did not follow the Management of Insulin, Narcotics and Controlled Drugs policy to ensure the drug count is completed by the outgoing and incoming nurses.

Rationale and Summary
A CIR regarding a medication incident involving a resident was submitted by the LTCH. The MLTC received a corresponding complaint related to the same incident.

There was a medication incident involving a resident and a controlled drug. The LTCH's policy on controlled drug counting requires two nurses, one from the outgoing shift and one from the incoming shift, to count and sign-off on the count sheet every shift change. The incoming nursing staff admitted that they did not count the controlled drugs with outgoing nursing staff. The nursing staff reported they counted the controlled drugs independently. The nursing staff reported that the drug count was correct, however they did not see that the previous nursing staff had administered a resident's medication just before shift change. An hour later, the nursing staff administered the same dose of the drug to the resident resulting in a medication error.

The nursing staff were aware of the LTCH's policy on controlled drug counting and confirmed it was not acceptable for only one nurse to count controlled drugs. The ADOC acknowledged the staff did not perform the controlled drug count correctly and this may have contributed to the medication error.

The resident was at risk of an overdose when the nursing staff failed to count controlled drugs together in accordance with the LTCH's policy.

Sources: A resident's clinical record, LTCH's investigation notes, LTCH policy Management of Insulin, Narcotics and Controlled Drugs, interviews with nursing staff, ADOC and others.

WRITTEN NOTIFICATION: Residents' drug regimes

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (b)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(b) appropriate actions are taken in response to any medication incident involving a

resident, any incidents of severe hypoglycemia and unresponsive hypoglycemia and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

The licensee has failed to ensure appropriate actions were taken in response to a medication incident involving a resident.

Rationale and Summary
A CIR concerning a medication incident involving a resident was submitted by the LTCH. The MLTC received a corresponding complaint related to the same incident.

The resident was to receive a medication as part of their treatment plan. The nursing staff administered the drug at the end of their shift but did not document that the resident received the medication. Another nursing staff administered the same drug and dose to the resident approximately one hour later.

The medication error was identified by the nursing staff shortly after the second dose was administered. A nursing staff and the ADOC informed the nurse to assess and monitor the resident and call the physician and family. The nursing staff reported that they assessed the resident and called the physician and the resident's family. This occurred approximately an hour and a half after the medication incident was first discovered. The nursing staff documented later in the shift that they reassessed the resident.

The ADOC reported that staff are expected to immediately assess the resident and contact the physician in the event of a medication incident. The nursing staff admitted they did not complete further monitoring of the resident after the medication incident, and they falsified documentation to indicate that they were monitoring the resident.

The resident's well-being was jeopardized when the appropriate actions were not taken by the nursing staff after a medication incident.

Sources: A resident's clinical record, LTCH's investigation notes, LTCH policy Medication Incident and Reporting, interviews with nursing staff and ADOC.

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (5)
Construction, renovation, etc., of homes
s. 356 (5) A licensee who has received the Director's approval under subsection (3) shall ensure that the work is carried out in accordance with the plan or specifications and work plan provided under subsection (4).

The licensee has failed to ensure that the Director's approval under subsection (3) shall ensure that the work was carried out in accordance with the plan or specifications and work plan provided under subsection (4).

Rationale and Summary
A complaint was submitted to the Director alleging concerns with infection prevention and control (IPAC) and resident care and support services impacted by the home's sprinkler installation project.

As per the operational plan submitted, a sprinkler system was to be installed in the building which included two long-term care (LTC) floors. Each LTC floor consisted of two resident home areas (RHAs) connected with a link hallway. The plan had also stated that the sprinklers were to be installed one hallway at a time, and only up to about 24 residents were to be moved to the main floor while work was being

completed in their rooms and the hallway. Furthermore, the construction was to be moved to a non-outbreak unit should there is an outbreak on the planned unit.

Upon commencing the onsite inspection, the third floor was experiencing an infectious disease outbreak.

A review of the home's electronic communication included a revised sprinkler installation timeline stating construction was to begin on the second floor RHAs and the hallway in early September, where the third floor had a delayed start date of mid-October.

A tour of the second floor was conducted during business hours and all residents were already portered to the ground floor at that time. Additionally, more than 100 resident beds were present on the ground floor at the time of observation.

As per the home's Executive Director (ED), there was a change to the sprinkler installation schedule as the third floor was experiencing an outbreak and the work was to begin for the second floor in order to meet the project deadline.

Failure to ensure the work was carried out in accordance with the plan might potentially expose the second floor residents to infectious diseases and impacting their quality of life.

Sources: home's electronic communication, operational plan and project schedule, observations, and interview with the ED.