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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: November 25, 2024
Inspection Number: 2024-1157-0003
Inspection Type: Complaint Critical Incident
Licensee: Tendercare Nursing Homes Limited
Long Term Care Home and City: Tendercare Living Centre, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 18 - 22 and 25, 2024

The following intake(s) were inspected:

- Intake: #00127962 - CIS # 2649-000050-24 - Resident fall resulting in an injury.
- Intake: #00129640 - Complaint related to resident care.
- Intake: #00129675 - CIS # 2649-000057-24 - Missing resident.
- Intake: #00130255 - CIS # 2649-000059-24 - Resident fall resulting in an injury.
- Intake: #00131379 - CIS # 2649-000060-24 - Alleged staff to resident abuse.

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

Medication Management
Safe and Secure Home
Infection Prevention and Control

Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to ensure that on a specific date a resident in the dinning room on the main floor, which had been converted into a resident resting area, was afforded privacy in treatment and in care for their personal needs.

Source
Observation and interview with the ADOC.
[641]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that on a specific date the home was a safe and secure environment for a resident, as they were able to elope through the front entrance of the home, and as a result, the resident sustained an injury.

Sources:
CIR #2649-000057-24, Interview with the ADOC.
[641]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 4.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

The licensee failed to ensure that the Director was immediately informed when a resident eloped from the home and returned with an injury requiring them to be sent to the hospital.

Sources
CIR #2649-000057-24, Interview with the ADOC.
[641]

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed within one business day of a resident injury that caused a significant change in status and transfer to hospital.

Sources:
Review of Critical Incident Report #2649-000059-24, Interview with ADOC, and review of resident's record.
[740788]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure drugs stored in a medication cart were secured and locked.

Sources:
Inspector's observation, and discussion with Registered staff.
[740788]