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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 2, 2025
Original Report Issue Date: June 9, 2025
Inspection Number: 2025-1157-0005 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Tendercare Nursing Homes Limited
Long Term Care Home and City: Tendercare Living Centre, Scarborough

AMENDED INSPECTION SUMMARY

This report has been amended to:
Non-compliance #002 written notification was amended to correct from s. 7 to section 2 of Ontario Regulations. Non-compliance #009, compliance order #002 was amended to correct the sources acronym DDS to DSM, with no changes to the compliance due date. Non-compliance #010, compliance order #003 was amended to correct condition 1. of acronym ED to Executive Director (ED), with no changes to the compliance due date. Non-compliance #008, compliance order #001 is included in the report, however was not amended. Therefore, each compliance order continues to have a compliance due date of September 4, 2025, with the issued date of June 9, 2025.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 21-23, 26-30, 2025 and June 2-6, and 9 2025.
The following intake(s) were inspected:

- An intake related to staff to resident abuse.
- An intake related to staff to resident abuse.
- An intake related to the fall of a resident.
- An intake related to Follow-up #: 1 - FLTCA, 2021 - s. 77 (2) Director of Nursing and Personal Care.
- An intake related to the improper care of a resident.
- An intake related to the neglect of a resident.
- An intake related to the improper care of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1157-0004 related to FLTCA, 2021, s. 77 (2)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The license failed to ensure that a resident's plan of care provided clear direction to staff related to an intervention,

A Critical Incident Report (CIR) was submitted related to the fall of a resident. The resident's clinical records and assessments completed by a member of the interdisciplinary team, provided indication of the resident's interventions. The resident's care plan did not correspond with the interdisciplinary assessments. An interview with a PSW indicated that this aspect of the care plan was not implemented.

Sources: A resident's clinical records, internal investigation notes, CIR and interviews with a PSW and a member of the interdisciplinary team.

WRITTEN NOTIFICATION: Duty to protect

NC #002 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 failed to ensure that a resident was not physically abused by a Personal Support Worker (PSW).

Ontario Regulation 246/22, section 2 states that “physical abuse” means the use of physical force by anyone other than a resident that causes physical injury or pain. It also states that “emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. The home submitted a CIR indicating that a PSW witnessed another PSW physically abuse a resident during care. The home conducted an internal investigation and substantiated the allegation, resulting in the PSW's termination. Investigation notes indicated that the resident was stunned, fearful and experienced redness on their face. Interviews with a PSW and Registered Practical Nurse (RPN) indicated that the PSW involved in the incident continued to provide care to the resident's roommate and was not immediately placed on an administrative leave. The PSW further indicated that they did not intervene or immediately report the witnessed abuse and acknowledged that this may have compromised the resident's safety.

Sources: A resident's clinical records, CIR, the home's investigation notes, a PSW's statement, and interviews with a PSW and RPN.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 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 failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with when a PSW witnessed another PSW physically abuse a resident and did not intervene or report this immediately. The home's policy on zero tolerance of resident abuse and neglect indicated that 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.

Interviews with the PSW and RPN indicated that the PSW that witnessed the incident did not intervene, or immediately report the witnessed abuse of the resident and left them alone with the abuser.

Sources: Zero Tolerance of Resident Abuse and Neglect Policy, investigation notes, and interviews with a PSW and RPN.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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 failed to immediately report the alleged neglect of a resident. A CIR was submitted on a specified date, although the home was aware of the alleged neglect a day before the specified date. The DOC acknowledged that staff failed to immediately inform the Director.

Sources: Zero Tolerance of Resident Abuse and Neglect Policy, CIR, and interview with DOC.

WRITTEN NOTIFICATION: Bathing

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was provided two baths over the course of one week.

A resident's clinical records indicated they were not provided assistance with bathing during specified dates. There was no documentation to indicate the resident refused or that reattempts were provided. The Nurse Manager confirmed that the resident was to receive two baths during each week and that if the resident were to refuse, the expectation was that staff document the resident's refusal, and reattempts offered.

Sources: Personal Care Policy, CIR, resident's clinical records and interview with the Nurse Manger.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that a resident's personal belongings were labelled within 48 hours of admission.

The Director was made aware of a complaint related to a resident's missing personal belongings. A PSW indicated that residents personal belongings are accounted for by the nursing department and labeled by the laundry staff. The PSW and the Nurse Manager could not confirm that the process was followed.

Sources: Personal Clothing and Linen Processes, CIR, a resident's clinical records and interview with a PSW and Nurse Manger.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (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 nutritional care and dietary services and hydration;

The licensee failed to ensure that the Nutrition Care and Hydration program was implemented when a resident had alterations to their diet order without consulting the Registered Dietitian (RD).

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the nutritional care and hydration program were implemented. Specifically the home's policy on Nutrition Care and Hydration indicated that the RD must discontinue/write new orders as required, and that the nurse must enter the orders for pharmacy and enter the new orders into the Medication Administration Record (MAR).

Clinical records indicated that when the resident had their dietary orders changed, there was no referral to the RD, no assessments by the RD, and no changes made to the MAR. Interview with the RD confirmed this.

Sources: The home's policy on Nutrition Care and Hydration, clinical records for the resident, and an interview with the RD.

COMPLIANCE ORDER CO #001 Falls prevention and management

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Educate all PSW's, Registered staff and agency staff working on two Resident Home Areas (RHA). The education shall include the risks associated with falls, types of falls prevention measures offered in the home, and the expectations related to documentation, including the revision of resident's care plans.
2. The DOC, Physiotherapist or management designate shall also educate all PSW's, Registered staff and agency staff assisting a specified resident on their falls prevention interventions, expectations related to documentation if an intervention cannot be implemented, and reassessments if an intervention is ineffective.
3. The licensee shall maintain a written record of the contents of the education provided from part 1 and 2 of the order, the dates the education was provided, the staff members that attended the education, signatures of the staff members acknowledging their understanding of the education they received, and the individual that provided the training.

Grounds

1. The license failed to ensure that a resident's fall prevention measures were in place.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, the home's falls policy indicated that falls prevention measures are to be implemented as outlined on the resident's plan of care.

The Director was informed of a fall involving a resident. The resident's clinical health records indicated an intervention was to be implemented. During an observation conducted during the inspection, the resident was observed without this intervention. The DOC confirmed that the expectation is that resident's intervention be implemented.

By failing to ensure to ensure that the resident's fall prevention intervention were in place, the resident was at an increased risk of sustaining additional injuries.

Sources: A resident's clinical health records, Falls Prevention and Management Program Policy, observations, and interview with the DOC.

2. The licensee has failed to ensure that a resident's falls prevention intervention was applied.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, the home's falls policy indicated that a resident's care plan is to be updated and revised as needed.

A CIR was submitted involving the neglect of a resident. The resident's clinical records indicated that an intervention be implemented. During an observation of the resident's room, conducted during the inspection, there was no indication that the intervention was utilized. A PSW confirmed that this intervention was not

implemented for the resident.

Failing to ensure that a resident's falls prevention interventions were implemented, posed an increased risk of the resident sustaining injuries related to falls.

Sources: Falls Prevention and Management Program Policy, CIR, a resident's clinical records and interview with Nurse Manger.

This order must be complied with by September 4, 2025

COMPLIANCE ORDER CO #002 Dining and snack service

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. The Dietary Service Manager, DOC or designate shall collaborate, develop and implement a written plan detailing the process to ensure that food service workers, recreation staff, volunteers and other staff assisting residents are aware of the residents' diets, special needs and preferences when the home's electronic system is unavailable.
2. The Dietary Service Manager, DOC or designate shall provide training to all staff participating in dining room services on the written process.

3. After the education is completed, the Dietary Service Manager, DOC, Food Service Supervisor or designate shall complete two dining room service audits over the course of three weeks during lunch and dinner meal services to ensure staff are following the newly revised process from part #1 of the order. The audits shall include the name of the auditor, date of the audit, time of the audit, name of staff audited, name of two residents selected for the audit and their diet orders, and whether the correct diet order was provided. When the auditor identifies that the written plan is not followed, the auditor shall provide immediate retraining, obtain the staff's signature acknowledging that they have received training and document the immediate training/corrective actions provided.
4. Retain a written record of the items in conditions 1 through 3 and provide documentation upon request of the inspector.

Grounds

The licensee failed to ensure that the Nutrition Care and Hydration program was implemented when a process to verify the dietary orders for the residents was not followed.

1. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the nutritional care and hydration program were implemented. Specifically the home's policy on Meal Service and Dining Experience indicated that staff were to refer to a diet list and therapeutic spreadsheet when plating meals as per resident selection.

A CIR was submitted by the home related to improper and incompetent treatment of a resident. The CIR indicated that the resident required a specified diet texture type and was instead given the incorrect diet texture for a number of days. According to the home's investigation notes, the resident was not assessed for these changes, and no documented changes were made to their diet orders. The

investigation notes confirmed that the resident was not provided the correct diet texture and that the home did not follow their process to verify dietary orders.

As a result of the resident's downgraded texture, a dietary referral to the Registered Dietician was completed due to poor food and fluid intake.

Sources: CIR, the home's policy titled Meal Service and Dining Experience, the resident's clinical records, the home's investigation notes, observations, and interviews with the Food Service Supervisor (FSS), the Dietary Service Manager (DSM) and PSW.

2. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the nutritional care and hydration program were implemented. Specifically the home’s policy on Meal Service and Dining Experience indicated that staff were to refer to a diet list and therapeutic spreadsheet when plating meals as per resident selection. The policy further indicated that meals should be ordered by stating name and meal choice.

During a meal observation, three PSWs verbally requested meals from the dietary aides by indicating diet texture. The FSS and a PSW indicated that the staff were supposed to use an electronic device to offer and select meal choices for the residents. The selected information would then display on a monitor along with the residents diet orders and allergens. The dietary aides were to then verify the orders and prepare the meals. The FSS and a PSW further indicated that this process was not followed since one of the electronic devices was not working. The FSS who was present for the meal service observation, confirmed that a PSW ordered the meals by diet texture without indicating the resident's name, and that the dietary servers provided the meals as per the PSW's request without verifying the resident and their dietary order. The FSS indicated that the expectation was to call out the resident's name and diet order for the dietary aide to verify the information against

a binder that contains all of the residents diet orders.

There was a risk of harm to several residents, when the dietary aides did not verify the diet orders being served. The risks included incorrectly serving the residents foods that are a choking/aspiration risk and or foods containing allergens.

Sources: CIR, the home's policy titled Meal Service and Dining Experience, observations, and interviews with the FSS, the DSM and a PSW.

This order must be complied with by September 4, 2025

COMPLIANCE ORDER CO #003 Additional training — direct care staff

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. The Executive Director (ED) and management team shall develop and implement a written plan and system that ensures all PSW's, Registered staff, and agency staff receive annual training on abuse recognition and prevention and managing

expressions of responsive behaviours. The written plan shall include, steps taken to ensure annual completion, measures in place for staff off on leave, and steps to ensure agency staff receive the required education.
2. The ED and the corporate consultant shall educate the orientation and training lead on the annual training requirements for direct care staff and the system that was developed from part 1 of the order to ensure that all PSWs, Registered staff and agency staff receive annual training. The ED and the corporate consultant shall document and maintain a written record of the education provided, the dates the education was provided, the staff members that attended the education, signatures of the staff members acknowledging their understanding of the education they received, and the individual that provided the training.
3. Retain a written record of the items in conditions 1 through 2 and provide documentation upon request of the inspector.

Grounds

1. The licensee failed to ensure that a PSW who provided direct care to residents, received training annually on abuse recognition and prevention.

In accordance with O. Reg 246/22 section 261 (2) 1. direct care staff are to receive annual training in the specified area under clause 82 (7) of the Act, specifically with abuse recognition and prevention. A CIR was submitted by the home related to an allegation of staff to resident abuse witnessed by a PSW. The PSW indicated that they did not intervene to stop the staff to resident abuse, and did not report the abuse immediately to the RPN. The PSW further indicated that they were not up to date with their training on abuse recognition and prevention and were uncertain of the procedures and protocols around reporting abuse. The PSW's training records indicated that they last received training outside of the annual requirement. There was a risk of continued harm to the resident when the PSW failed to intervene and immediately report the witnessed abuse.

Sources: Education records, interview with a PSW.

2. The licensee has failed to ensure that a RPN and Registered Nurse (RN) received additional training in responsive behaviour management annually.

In accordance with O. Reg 246/22 section 261 (2) 1. direct care staff are to receive annual training in the specified area under clause 82 (7) of the Act, specifically in the management of a residents behaviors. An incident of neglect involving a resident was reported to the Director. A RPN and RN failed to manage the responsive behaviours of a resident on two separate occasions. On review of the education records for the RN, the last date they received training was outside of the annual requirement. At the time of the inspection, the home was unable to provide education or training records for the RPN. During an interview with the home's Nurse Manager, they indicated the expectation is education pertaining to responsive behaviours is annually.

By failing to ensure that the RPN and RN, received annual training, there was an increased risk to the management of a resident's responsive behaviorus.

Sources: Education records, interview with Nurse Manager.

This order must be complied with by September 4, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar

151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.