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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2016	2015_333577_0017	029573-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF THUNDER BAY
c/o Dawson Court 523 Algoma Street North THUNDER BAY ON P7A 5C2

Long-Term Care Home/Foyer de soins de longue durée

PIONEER RIDGE
750 TUNGSTEN STREET THUNDER BAY ON P7B 6R1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DEBBIE WARPULA (577), LAUREN TENHUNEN (196), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 2, 3, 4, 5, 6, 9, 10, 11 and 12, 2015

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous policies, procedures and programs.

Additional logs were inspected during the RQI: #09766-14, #21811-15, #00621-15, #26312-15, #15413-15 and #15449-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Nursing(ADON), RAI Coordinator, Maintenance staff, Life Enrichment Supervisor, Food Services Supervisor, Environmental Services Supervisor, Housekeeping staff, Educator, Best Practice Clinician, Pharmacist, Social Worker, Registered Nurse(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Family Members and Residents

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #016 was protected from abuse by anyone.

A Critical Incident was submitted to the Ministry in June 2015, concerning an incident of resident to resident abuse involving residents #001 and #016 that occurred in June 2015. As per the C.I, resident #001 pushed resident #016 and the resident suffered a significant injury.

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident".

A record review of the progress notes for resident #001 revealed eight incidents of physical aggression against staff and co-residents that occurred over a three week period in 2015:
-on a particular day in 2015, resident #001 found wandering in other residents' rooms while they were sleeping. RN attempted to redirect and the resident pushed the RN.
-on another day in 2015, resident #001 attempted to eat off a covered lunch plate and grabbed at a staff member's chest and motioned to hit them with a fork when staff was assisting them.
-on another day in 2015, resident #001 barricaded the doorway of the tv room, threw coffee and punched and kicked at staff.
-on another day in 2015, resident #001 refused care and was very agitated showing fists to staff and other residents.
-on another day in 2015, resident #001 was pacing at nursing station, combative with staff when redirected to their room.
-on another day in 2015, resident #001 urinated on the floor and attempted to hit staff when redirected.
-on another day in 2015, resident #001 was pacing the unit, fidgeting, shadowing staff and unable to settle.
-on another day in 2015, resident #001 was standing near resident #016 who had fallen to the floor. Co-residents were yelling at resident #001. Staff attempted to re-direct and resident #001 grabbed a broom from the housekeeping cart and swung it at staff.

A record review of the progress notes for resident #016 revealed the following:
-on one day in 2015, resident #016 was found on the floor beside the nursing station.
-on another day in 2015, resident #016 was transferred to the hospital and diagnosed with a significant injury.

In an interview with the ADON, they revealed that they had reviewed camera surveillance at the nursing station from a particular day in June 2015, confirming that resident #001

had pushed resident #016 to the floor. They had determined that abuse had occurred and reported it to the Director.

A review of the RAI-MDS assessment for resident #001, effective for the period of April 28, 2015, to July 29, 2015, revealed that resident #001 had responsive behaviors.

A review of the care plan for resident #001, in effect for the time of the incident, with a nursing focus "behaviour problem", revealed the following interventions:
-for periods of aggression, staff were to leave and re-approach at a later time
-staff to administer psychotropic medication as ordered by the physician when resident #001 became angry or raised their fist.

A review of resident #001's health records revealed that a referral was sent to Behavioural Support Ontario (BSO) who came into the home to assess the resident in June 2015. Their assessment indicated that resident #001 exhibited numerous responsive behaviours. BSO left the following strategies for inclusion in the resident's care plan:
-when agitated, monitor for pain, need to toilet, rest or re-approach at a different time
-resident is triggered by an over stimulated environment
-aggression is a result of fear, reassure resident that they are safe, distract and redirect
-Montessori activities would be beneficial
-keep familiar objects in room

A review of the care plan for resident #001, revealed that the BSO strategies were not included in the resident's care plan.

During an interview with the Inspector, RN #119 and RPN #114 both confirmed that strategies recommended by BSO staff were not implemented in the plan of care.

A review of the City of Thunder Bay Homes for the Aged policy titled, "Abuse and Neglect", revealed that the City of Thunder Bay Homes for the Aged were committed to ensuring that steps were taken to prevent the risk of abuse to all persons in the home by: management of responsive behaviours.

The home was aware of resident #001's responsive behaviours towards others but did not ensure that appropriate safety measures were in place to protect other residents.

Non-related non-compliance has been previously identified.

The decision to issue this compliance order was based on the scope which affected one resident and the severity which indicates actual harm. [s. 19. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for resident #006 that set out clear directions to staff and others who provide direct care to the resident.

Resident #006 suffered a fall with a significant injury in August 2015.

A review of resident #006's care plan revealed under the focus 'risk of injury from falls', the interventions gave conflicting information regarding area of injury.

The resident's care plan gave unclear directions concerning the location of their injury. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provide direct care to the resident.

Observations made on November 2 and 6, 2015, revealed resident #002 lying in their bed with two quarter bed rails elevated.

An interview with PSW #120 revealed that resident #002 used two full bed rails for safety.

An interview with RPN #121 revealed that resident used two 3/4 bed rails for safety, and that resident was a fall risk. They further reported that bed rails were documented in the care plan.

An interview with the Best Practice Coordinator revealed that bed rails should have been documented in the resident's care plan.

An interview with PSW #122 revealed that resident #002 used two half bed rails for bed mobility and turning.

A review of resident #002's care plan, 24 hour admission care plan and physiotherapy notes, confirmed no documentation indicating bed rails for resident #002. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A review of resident #001's care plan revealed that the resident had continence needs, and included interventions for staff to follow.

A review of resident #001's MDS assessment for the quarter ending July 2015, revealed that their disease process had contributed to a severe decline in cognition and a change

in continence status.

An interview with PSW #127 revealed that the resident was not shown where the bathroom in their room was. Staff would watch for signs that indicated they needed the toilet, and further that the resident was unable to find the toilet on their own. They further revealed that they did not toilet the resident today, and that the resident was incontinent of bowel a short time ago, after lunch. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #022 as specified in the plan.

Observations made on November 10, 2015, at 1410hr, revealed resident #022 seated in their wheelchair with a front closing seat belt in place but did not have a chair alarm or seat belt alarm.

A review of the current care plan revealed under the focus of "risk of injury from falls" the intervention of "seat belt alarm for wheelchair, ensure it is functioning when in use". Under the focus of "ADL assistance" the intervention of "chair alarm and lap belt".

An interview with RPN #124 revealed that a chair alarm and seat belt alarm were the same safety device and proceeded to put an alarm on the chair as there was not one in use at the time of the observation. [s. 6. (7)]

5. The licensee has failed to ensure that resident #022 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 is no longer necessary.

A review of the current care plan for resident #022 regarding continence care needs revealed under the focus of "ADL assistance" the intervention of "toileting: total assistance on scheduled toileting routine. Infection precautions.

Observations made of resident's room and signage revealed no evidence that would identify infection control precautions.

An interview with PSW #123 and RPN #124 revealed that resident #022 was no longer under infection precautions. [s. 6. (10) (b)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, specifically in regards to residents #006 and #002; and that the care set out in the plan of care is provided to the resident as specified in the plan, specifically in regards to residents #001 and #022; and that the resident is 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 is no longer necessary, specifically in regards to resident #022, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Observations made on November 2 and 6, 2015, revealed resident #002 lying in their bed with two quarter bed rails elevated.

A review of the residents care plan, 24 hour plan of care completed on admission and progress notes did not indicate bed rails.

An interview with PSW #120 revealed that resident #002 uses two full bed rails for safety.

An interview with RPN #121 revealed that the resident uses two 3/4 bed rails for safety, and that resident was a fall risk. They further reported that nursing staff determines whether a resident needs bed rails and it is documented in the care plan.

An interview with the Best Practice Coordinator/BPC revealed that bed rails should be documented in the care plan and nursing staff will determine if and how many rails are needed.

An interview with PSW #122 revealed that resident #002 used two half bed rails for bed mobility and turning.

An interview with the Environmental Services Supervisor/ESS confirmed that residents had not been assessed for the use of bed rails.

The home failed to provide any documented assessments for bed rails. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Observations made on November 9, 2015, by the Inspector and the Environmental Services Supervisor, confirmed that resident #021's middle bed rails were loose.

An interview with the Maintenance worker #129,in the presence of the Supervisor revealed that Cardinal Health came to the home in May 2015, used a machine and checked all the beds in the building, which included checking the beds for mattress fit, entrapment areas and the latching of the bed rails. The Maintenance worker revealed that they were not sure if they ever received a copy of the audit from Cardinal Health, but did have a handwritten list of beds in the home that were identified as having entrapment issues. The maintenance worker confirmed that concerns identified from Cardinal health

had not been rectified. [s. 15. (1) (a)]

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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, specifically in regards to residents #002 and #021, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her 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 O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Observations made on November 2, 2015, at 0945hr, of a tub room revealed one unlabelled comb with hair and debris on the sink counter and an unlabelled, used men's stick deodorant on the counter top. In addition, there was a sign on the inside tub room door that indicated that all resident specific items are to be labelled. [s. 37. (1) (a)]

2. The licensee has failed to ensure that each resident of the home had his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new

items.

Observations made on November 2, 2015, during the initial tour of the home on a unit, revealed used and unlabelled personal items stored in the unlocked metal cabinet on the wall in the common toilet across from nursing station:
-three containers of talcum powder
-two containers of "Derma Plus Tranquil" skin lotion
-one bottle of mineral oil which had an expiration date of June 1999
-one "Arid" roll on deodorant.

An interview with PSW #104 revealed that all residents accessed the common washroom across from the nursing station and that the cupboard containing the products should have been locked to maintain the safety of residents on the unit.

Observations made on another unit's tub room revealed the following used and unlabelled personal items stored in the cabinets:
- three bottles of talcum powder
- two containers of vitarub
- one container of petroleum jelly
- tube of barrier cream.

An interview with PSW #105 revealed that the powders and creams in the cupboard are extras that would be used on all residents using the tub room.

Observations made during the initial tour of the home on another unit, revealed the following used and unlabelled personal items stored in the cabinets in the right corridor tub room:
-four bottles of talcum powder
-three unlabelled hair brushes with hair in them
-one deodorant.

An interview with PSW #106 revealed that the personal products that were found in the tub room should have been labelled and confirmed that they were used for residents using the tub. [s. 37. (1) (a)]

3. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids

cleaned as required.

Observations made on November 3, 2015, at 1030hr, revealed resident #024 seated in a tilt wheelchair and the seat belt was soiled with food debris.

Observations made on November 5, 2015, at 1615hr, revealed resident #021 seated in their tilt wheelchair and their seat belt was soiled with dry food debris.

Observations made on November 6, 2015, at 1250hr, revealed resident #021 seated in a tilt wheelchair and the seat cushion of the chair was soiled with food debris.

Observations made on November 6, 2015, at 1315hr, revealed resident #022 seated in their wheelchair and the seat cushion was soiled with food debris.

Observations made on November 9, 2015, at 1445hr, revealed resident #021 in same clothes, food debris unchanged on seat cushion, "loonie" sized piece of food on foot rest under heel dressing, and food debris in the crevices of the wheelchair. [s. 37. (1) (b)]

4. The licensee has failed to ensure that resident #014 had his personal items, including personal aids such as dentures, glasses and hearing aids cleaned as required.

Observations made on November 3, 2015, revealed resident #014's tilt chair, seat belt soiled with dry food debris. Observations made on November 9, 2015, at 1107hr, revealed resident #014 sitting in their wheelchair and the arm rests and the seat belt of the wheelchair had dried food debris on it.

An interview with PSW #106 and RPN #111 revealed that resident wheelchairs were washed by night staff monthly using a wheelchair washer that is located on the unit. PSW #106 revealed that if chairs needed to be washed outside of the scheduled cleaning, it would be noted on the day pad/calendar at the desk.

A review of the calendar with PSW #106, through to October 10, 2015, revealed no record of request for an additional cleaning of any resident wheelchairs.

A review of the "wheelchair cleaning" document dated for the year 2015, revealed a list of residents for Plaza Four that required monthly wheelchair cleaning which indicated that the wheelchair for resident #018 had been signed that it was cleaned for the month of October. The wheelchair for resident #014 remained soiled with dried food debris. [s.

37. (1) (b)]

5. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids cleaned as required.

Observations made on November 3 and 9, 2015, revealed the wheelchair lapbelt and wheelchair cushion for resident #007 was soiled with food stains.

Observations made on November 12, 2015, revealed resident #007's wheelchair lapbelt and cushion soiled with food stains and debris. [s. 37. (1) (b)]

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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, specifically in regards to residents residing on the fourth, third and first floor; and that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids cleaned as required, specifically in regards to residents #014, #024, #021, #022, #014 and #007, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During the time of inspection, resident #002 was identified as having altered skin integrity.

A review of the altered skin integrity orders on November 9, 2015, revealed that resident #002 was to have their treatment completed every three days and as needed.

A review of the progress notes for weekly skin assessments from September 3-November 9, 2015, revealed no weekly assessments for the week of September 27, 2015, and the week of October 4, 2015, for one area of altered skin integrity; a weekly skin/wound assessment for other area wasn't initiated until November 9, 2015.

A review of the home's clinical tool, 'Wound/Skin Assessment' for the one area, revealed no documentation for the week of September 27, 2015. The 'Wound/Skin Assessment' for the other area wasn't initiated until November 9, 2015.

An interview with the Educator and Best Practice Coordinator, confirmed that the 'Wound/Skin Assessment' form is the home's clinical tool that was used for weekly documentation.

An interview with the Best Practice Coordinator confirmed that the Treatment Administration Record/TAR was documented on for each dressing change and a weekly skin assessment was documented in the progress notes.

A review of the 'Wound/Skin Assessment' form revealed, "all assessments must also be documented on progress notes".

A review of the home's policy, 'Skin Care and Wound Management Program', with revision date of January 2015, revealed on page 3 of policy, 'each resident who exhibits skin breakdown and/or wounds shall be assessed each week or more frequently, if needed, by a member of the register nursing staff. (weekly skin ulcer tool can be used to collect information required for documenting). All skin assessments are documented in the progress notes. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, specifically in regards to resident #002, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives 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; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #013 received a continence assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A review of RAI MDS quarterly assessments dated August 3, 2015, and May 10, 2015, and a care plan last updated August 21, 2015 for resident #013 revealed that the resident had continence concerns. Resident #013 used supplies and required staff assistance.

A review of the health care records revealed no continence care assessment for resident

#013, that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

An interview with RPN #113, RPN #114 and RPN #115 confirmed that there wasn't a continence assessment completed for resident #013.

An interview with the Nursing Unit Support Worker confirmed that a continence assessment was not completed.

An interview with the Educator and Best Practice Coordinator confirmed that for all resident admissions, a hard copy continence assessment was to be completed.

A review of the City of Thunder Bay Homes for the Aged policy titled, "Bladder and Bowel Management Program", revealed that the registered nursing staff were responsible to have completed a continence care and bowel assessment using the Continence Assessment Form.

In an interview with the ADON, they confirmed that it was the home's expectation for the staff to have completed the continence assessment for resident #013. [s. 51. (2) (a)]

2. The licensee has failed to ensure that each resident who was incontinent received an assessment that included 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 was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A review of resident #001's MDS quarterly assessment for period ending in July 2015, revealed that resident's disease process had contributed to a severe decline in cognition and change in continence status. Their most current MDS for observation period ending October 26, 2015, revealed that the resident had specific continence needs.

A review of the care plan revealed that the resident had continence concerns.

A review of the health records revealed that a continence assessment was not completed using a clinically appropriate assessment instrument that was specifically designed for incontinence.

An interview with the Best Practice Coordinator confirmed that the home's continence assessment was a paper assessment form, completed on admission. They further confirmed that residents' continence requirements are not re-assessed when there is a change in continence.

An interview with the Educator revealed that the Continence Assessment Form is completed on admission, quarterly and whenever there is a change in condition, but there was no documentation to support this was done for resident #001.

A review of the home's "Bladder and Bowel Management Program", with a revision date of January 2015, revealed that staff are to complete the Continence Assessment Form and required electronic assessments within 14 days of admission. [s. 51. (2) (a)]

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 each resident who is incontinent receives 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, specifically in regards to residents #013 and #001, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of resident #002's medication/treatment notes for prn medication and resident responsiveness revealed that the resident received analgesia at various times over a six day period and the effectiveness was documented as 'no effect', 'ineffective' and 'little effect'.

An interview with RPN #131 revealed that staff will assess pain by the resident verbally expressing pain but mostly it is non-verbal ques, like moaning and facial grimacing. They also reported that they will initiate an electronic pain assessment with significant changes and when pain is not controlled, otherwise it is done annually and quarterly.

An interview with the Best Practice Coordinator revealed that staff do not use a clinical tool to reassess unrelieved pain.

In an interview with the ADON, they could not confirm whether the home had a clinical tool to reassess for unrelieved pain.

An interview with the Best Practice Coordinator revealed that four electronic pain assessments were completed in May 2015, August 2015, November 2015, and November 2015. The Pain assessments completed in May, August and November 2015 were quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS), and not assessments using an assessment instrument specifically designed for pain assessment.

There were no pain assessments found using a clinically appropriate assessment instrument specifically designed for pain assessment completed for the dates above when the resident was experiencing unrelieved pain. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, specifically in regards to resident #002, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council had advised the licensee of concerns or recommendations, the licensee did not respond in writing within ten days.

An interview with the chair of the Family Council revealed that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations raised at the Family Council meetings. The response to the concerns or recommendations raised at those meetings were documented as part of the minutes. The chair of the Family Council revealed that a copy of the minutes was not given out until the next meeting, three months later.

An interview with the Administrator confirmed that the resolutions to the concerns and recommendations brought forward at the Family Council meetings had not been submitted within 10 days to the council chair and they did not respond for three months after they received the concerns. [s. 60. (2)]

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 when the Family Council has advised the licensee of concerns or recommendations, the licensee shall respond in writing within ten days, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of

abuse and neglect of residents were posted.

Observations made on November 2, 2015, of the bulletin board on the second level of the home across from the elevator revealed that the posting of the home's policy to promote zero tolerance of abuse and neglect of residents was not posted. The policy was not posted in a conspicuous and easily accessible location, anywhere in the home.

An interview with the Administrator confirmed that the posting for the policy regarding zero tolerance of abuse and neglect of residents was missing and they were not able to identify how long it had been missing from the bulletin board. [s. 79. (3) (c)]

2. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted.

Observations made on November 2, 2015, revealed a compilation of the Ministry of Health and Long Term Care (MOHLTC) inspection reports held together with a clip posted on the bulletin board on the second level of the home on the wall across from the elevator. The following inspection reports were missing from the posting:
2014_320576_0005 - Critical Incident System follow up related to prevention of abuse, neglect and retaliation
2013_211106_0040 - Complaint follow up related to personal support services
2013_211106_0041 - Follow up to minimizing of restraints and responsive behaviours

An interview with the Administrator confirmed that the three MOHLTC reports were missing from the posting in the home. [s. 79. (3) (k)]

3. The licensee has failed to ensure that an explanation of whistle-blowing protections related to retaliation were posted.

Observations made on November 2, 2015, of the bulletin board on the wall across from the elevator on the second level revealed various postings related to long term care. The posting for an explanation of whistle-blowing protections related to retaliation was not posted.

An interview with the Administrator confirmed that the posting for an explanation of whistle-blowing protections related to retaliation was not posted in the home. [s. 79. (3) (p)]

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 required information for the long-term care home's policy to promote zero tolerance of abuse and neglect of residents are posted; to ensure that the required information, copies of the inspection reports from the past two years for the long-term care home are posted; to ensure that the required information, an explanation of whistle-blowing protections related to retaliation for the long-term care home is posted, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

Observations made on November 6, 2015,revealed topical prescription creams in five separate plastic bins on the shelf at the nursing desk on one of the units and the creams were not locked up.

An interview with RPN #124 revealed that the plastic bins are placed there at the start of the shift for the PSW's to take and put on their carts for use during their shift and the next shift at 1630hr would be taking the bins that remain on the shelf.

An interview with the ADON revealed that the plastic bins with topical prescription creams should be locked up either in the medication room or the locked utility room and not to be kept at the nursing desk.

A review of the licensee's policy for "Medication storage in the facility" revealed that "medications are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier, and in accordance with federal and provincial laws and regulations. The medication supply is accessible only to authorized personnel" and "medication storage areas, rooms, and carts are kept locked". [s. 129. (1) (a)]

2. The licensee failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies.

A review of the medication carts on one of the units, on November 4, 2015, revealed a plastic bag that contained wound care dressing supplies with a resident first name hand written on the bag and hearing aids for several residents.

An interview with RPN #124 revealed that those supplies should be kept on the treatment cart and not in the medication cart. [s. 129. (1) (a)]

3. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

Observations made on November 2, 2015, at 0950hr, revealed an unlocked resident care cart on one of the units with a tube of prescription cream for resident #025 and a container of prescription cream for resident #026.

Observations made on November 2, 2015, revealed PSW #133 lock the cart after the inspector brought it to their attention. [s. 129. (1) (a) (ii)]

4. A review of the licensee's policy for "Medication storage in the facility" revealed that "medications are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier, and in accordance with federal and provincial

laws and regulations. The medication supply is accessible only to authorized personnel" and "medication storage areas, rooms, and carts are kept locked". [s. 129. (1) (a) (ii)]

5. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Observations made on November 6, 2015, at 1300hr, on one of the units revealed an open ampule of liquid narcotic medication with solution present, placed in a plastic medication cup on top of the medication cart. Observations further revealed during the administration of medications to residents, the cart was pushed along in the corridor and the substance remained on the cart.

An interview with RPN #134 revealed that they were waiting to dispose of the open ampule with the other RPN. [s. 129. (1) (b)]

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 drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies; and to ensure that drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of resident #002's medication/treatment notes and progress notes for prn medication and resident responsiveness revealed eight occurrences where the resident was given pain medication and there wasn't a documented response to the medication given.

An interview with RPN #121 revealed that staff document a progress note concerning effectiveness when prn medication is given for pain.

There were no progress notes found revealing a response to medication effectiveness for the dates above when the resident was given pain medication.

An interview with the Educator revealed that staff were expected to document on the medication/treatment notes for the effectiveness/ineffectiveness of prn pain medication and aren't expected to document a progress note. [s. 134. (a)]

2. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of the health care records for resident #021 revealed physician's orders for two medications for pain. A review of the progress notes for three months revealed no documentation of resident #021's response or effectiveness of the medication. A review of the most recent pain assessment, revealed complaints of pain.

An interview with RPN #135 revealed that during care of resident #021, they may become resistive when positioned in bed, and they often think it may be pain related.

An interview with the Best Practice Coordinator revealed that there was no documentation regarding resident #021's response or effectiveness of the medication that was ordered on August 29, 2015. [s. 134. (a)]

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #12: 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:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Observations made on November 2, 2015, at 0955hr, revealed an unlocked storage room across from a resident room, containing equipment and supplies.

Observations made on November 2, 2015, revealed PSW #136 lock the door on the storage room, after it was brought to their attention by the inspector. [s. 9. (1) 2.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observations made on November 3, 2015, revealed a hand soap dispenser removed from the wall in resident #001's and #012's room and the wall had not been repaired.

An interview with Environmental Services Worker #109 revealed that the hand soap dispensers had not been replaced in their room due to a safety risk for resident #012 who had dismantled them and that they should have notified the maintenance department to repair the wall but they had not done that.

An interview with the Environmental Services Supervisor confirmed that all required repairs to the home were communicated to the maintenance department by the "maintenance memo" and repairs were assigned to the maintenance staff and completed by priority. The Environmental Services Supervisor confirmed that the memos received from the units dated back two years did not contain a memo that requested repair of the wall in resident #001's and #012's room. [s. 15. (2) (c)]

WN #14: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Health conditions, including allergies, pain, risk of falls and other special needs.

A review of the health care records for resident #021 revealed a current physician's order for two medications.

A review of the progress notes over three months revealed no reference to pain.

A review of the most recent pain assessment revealed that the resident had pain.

An interview with the Best Practice Coordinator confirmed there was no reference to pain in the current care plan. [s. 26. (3) 10.]

WN #15: 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 has failed to ensure that the programs included, a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter.

A review of the health care records for four residents revealed that they were missing annual heights:
Resident #022, last height recorded April 2014
Resident #027, last height recorded April 2012
Resident #011, last height recorded March 2010
Resident #027, last height recorded April 2012

An interview with RPN #137 revealed that heights were documented at the time of admission and not recorded annually.

An interview with the RAI Coordinator revealed that annual heights were not being recorded for residents.

A review of the licensee's policy titled "Height and Weight Monitoring", with revision date of February 2014, revealed that "Body mass index and height both done on admission and annually thereafter". [s. 68. (2) (e) (ii)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping procedures were implemented for addressing incidents of lingering offensive odours.

Observations made over a three day period revealed that the shared bathroom floor for resident #012 and #001 was sticky and there was a lingering urine smell in their room.

An interview with Environmental Services Worker #112 revealed that resident #012 and #001 both soil the floor in their room and in their bathroom and that staff would clean the floor at least four times a day and that staff had access to a mop and pail in the housekeeping room.

An interview with the Environmental Services Supervisor #110 confirmed that residents #001 and #012 soil their floor and that there was an outside provider who supplies and maintains an odour eliminator system that is hung on the wall in the service elevators and in the public washrooms but is not used in that resident room.

A review of the City of Thunder Bay Homes for the Aged policy titled 'Housekeeping Services' revealed that housekeeping services provided in the home include a system to address offensive odours.

On multiple days during this inspection the inspector noted a lingering odour in the shared washroom of resident #012 and #001. Despite Environmental Service Workers mopping the floor multiple times per day, the odour remained and the home had not taken further action to address this odour. [s. 87. (2) (d)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

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. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to 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 (4): An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A Critical Incident Report was submitted to the Ministry in January 2015, which indicated an outbreak in the home. The outbreak had been declared by the public health unit in January 2015, and had not been reported to the Ministry until ten days later, on January 2015.

An interview with the ADOC revealed that they were unaware of the reason for the delay in reporting as it was a different DOC at that time and there was no record of a phone call being placed to the after hours pager to inform of the outbreak.

A second CI report was submitted to the Ministry in September 2015, indicating an outbreak in the home that had been declared by the public health unit.

An interview with the ADOC revealed that they had difficulty with submitting the report in September 18, 2015, and that they had called a number the following morning to report the outbreak but was not sure whom they had spoken to. They further revealed that the report was then submitted by the DOC at the time in September 2015.

The Director was not immediately informed of an outbreak in January 2015, and for an outbreak in September 2015, when they were both declared by the public health units. [s. 107. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

A review of the medication carts on one of the units on November 6, 2015, revealed a bottle of medication with resident #028's name handwritten on the bottle and another bottle of medication with resident #021's name handwritten on the bottle.

An interview with RPN #124 revealed that the family of resident #028 brings the medication in for the resident and further revealed that resident #021 was not currently receiving this medication and there wasn't an order for it to be given.

A review of the clinical records revealed there was an MD/RNEC order for this medication to be administered but that the pharmacy service provider had not supplied this for the resident.

An interview with the pharmacist from the pharmacy concerning natural health products and resident #028's medication revealed that this should be available from their pharmacy and that the home/pharmacy always have a MD/RNEC order for natural health products and over the counter medications.

A review of the licensee's policy titled "Medication Management - Overview" with approval date of October 2013, under the category of "Medication brought from home", revealed that "any medication brought in from home will either be returned with a responsible person or sent for drug destruction". [s. 122. (1)]

2. The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, has been prescribed for a resident.

Observations made on November 3, 2015, at 1500hr, revealed a bottle of vitamins on the bedside table in resident #029's room.

An interview with resident #028 revealed that they received them from the pharmacy.

An interview with PSW #124 revealed that resident did not have an MD order to have this medication and that the family must have brought it in for the resident. PSW #124 obtained the bottle from the residents room to store in the unit medication room.

A review of the health care records for resident #029 revealed that resident did not have an order for these vitamins. [s. 122. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the program.

Observations of medication administration for three residents on one of the units on November 6, 2015, at 1300hr, by RPN #134 revealed neither hand washing or hand sanitizer was used between residents. Observations revealed RPN #134 using a paper towel to wipe excess water and medication from around resident #030's mouth and nose then administered medication to resident #011.

An interview with the ADON confirmed that the home had a hand hygiene program and the expectation was that staff would wash hands or at least use a hand sanitizer as found on their medication carts, between residents during medication administration.

A review of records for 2014 and 2015 hand hygiene education revealed that RPN #134 participated in training for 2014, and had not yet completed training for 2015. [s. 229. (4)]

2. Observations made on November 6, 2015, at 1300hr, revealed the sharps container attached to the side of the medication cart on one of the units, to be full and three used syringes sticking out of the opening.

A review of the licensee's "Medication Policy and Procedure Manual for Long-Term Care" page 37 revealed "when a 'sharps' container is 2/3 full, it is sealed and disposed of with other hazardous waste, by the facility". [s. 229. (4)]

Issued on this 28th day of January, 2016

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), LAUREN TENHUNEN (196), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2015_333577_0017
Log No. / Registre no:	029573-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 27, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF THUNDER BAY c/o Dawson Court, 523 Algoma Street North, THUNDER BAY, ON, P7A-5C2
LTC Home / Foyer de SLD :	PIONEER RIDGE 750 TUNGSTEN STREET, THUNDER BAY, ON, P7B-6R1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lee Mesic

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

To THE CORPORATION OF THE CITY OF THUNDER BAY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that resident #016 and all other residents are protected from abuse by anyone and shall ensure that all residents are not neglected by staff.

The licensee shall:
a) ensure that strategies recommended by BSO staff are incorporated into the resident's plan of care.
b) ensure that the current plan of care for resident #001 is communicated to all staff who provide care to this resident and that the care set out in the plan of care is provided to resident #001.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #016 was protected from abuse by anyone.

A Critical Incident was submitted to the Ministry in June 2015, concerning an incident of resident to resident abuse involving residents #001 and #016 that occurred in June 2015. As per the C.I, resident #001 pushed resident #016 and the resident suffered a significant injury.

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident".

A record review of the progress notes for resident #001 revealed eight incidents of physical aggression against staff and co-residents that occurred over a three week period in 2015:
-on a particular day in 2015, resident #001 found wandering in other residents'

rooms while they were sleeping. RN attempted to redirect and the resident pushed the RN.
-on another day in 2015, resident #001 attempted to eat off a covered lunch plate and grabbed at a staff member's chest and motioned to hit them with a fork when staff was assisting them.
-on another day in 2015, resident #001 barricaded the doorway of the tv room, threw coffee and punched and kicked at staff.
-on another day in 2015, resident #001 refused care and was very agitated showing fists to staff and other residents.
-on another day in 2015, resident #001 was pacing at nursing station, combative with staff when redirected to their room.
-on another day in 2015, resident #001 urinated on the floor and attempted to hit staff when redirected.
-on another day in 2015, resident #001 was pacing the unit, fidgeting, shadowing staff and unable to settle.
-on another day in 2015, resident #001 was standing near resident #016 who had fallen to the floor. Co-residents were yelling at resident #001. Staff attempted to re-direct and resident #001 grabbed a broom from the housekeeping cart and swung it at staff.

A record review of the progress notes for resident #016 revealed the following:
-on one day in 2015, resident #016 was found on the floor beside the nursing station.
-on another day in 2015, resident #016 was transferred to the hospital and diagnosed with a significant injury.

In an interview with the ADON, they revealed that they had reviewed camera surveillance at the nursing station from a particular day in June 2015, confirming that resident #001 had pushed resident #016 to the floor. They had determined that abuse had occurred and reported it to the Director.

A review of the RAI-MDS assessment for resident #001, effective for the period of April 28, 2015, to July 29, 2015, revealed that resident #001 had responsive behaviors.

A review of the care plan for resident #001, in effect for the time of the incident, with a nursing focus "behaviour problem", revealed the following interventions:
-for periods of aggression, staff were to leave and re-approach at a later time
-staff to administer psychotropic medication as ordered by the physician when

resident #001 became angry or raised their fist.

A review of resident #001's health records revealed that a referral was sent to Behavioural Support Ontario (BSO) who came into the home to assess the resident in June 2015. Their assessment indicated that resident #001 exhibited numerous responsive behaviours. BSO left the following strategies for inclusion in the resident's care plan:
-when agitated, monitor for pain, need to toilet, rest or re-approach at a different time
-resident is triggered by an over stimulated environment
-aggression is a result of fear, reassure resident that they are safe, distract and redirect
-Montessori activities would be beneficial
-keep familiar objects in room

A review of the care plan for resident #001, revealed that the BSO strategies were not included in the resident's care plan.

During an interview with the Inspector, RN #119 and RPN #114 both confirmed that strategies recommended by BSO staff were not implemented in the plan of care.

A review of the City of Thunder Bay Homes for the Aged policy titled, "Abuse and Neglect", revealed that the City of Thunder Bay Homes for the Aged were committed to ensuring that steps were taken to prevent the risk of abuse to all persons in the home by: management of responsive behaviours.

The home was aware of resident #001's responsive behaviours towards others but did not ensure that appropriate safety measures were in place to protect other residents.

Non-related non-compliance has been previously identified.

The decision to issue this compliance order was based on the scope which affected one resident and the severity which indicates actual harm. [s. 19. (1)] (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 03, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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