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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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 25, 2017	2017_333577_0001	034793-16	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), JENNIFER KOSS (616), 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): January 9, 10, 11, 12, 13, 16, 17 and 18, 2017

Additional intakes inspected during this RQI include:

A complaint log submitted to the Director related to narcotic diversion;

Four critical incident log's the home submitted related to a resident bruising, alleged staff to resident abuse, missing narcotics and storage and security of narcotics.

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 resident health care records, and reviewed many of the homes policies, procedures and programs

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care (DOC), Clinical Manager, Environmental Services Manager (ESM), Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Best Practice Clinician, Recreation and Volunteer Services Supervisor, Recreation Therapist, Unit Coordinator, Housekeeper, Resident Council President, residents and family members

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **1 VPC(s)**
- **0 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 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 the resident exhibiting altered skin integrity, including pressure ulcers had been reassessed at least weekly by a member of the registered nursing staff.

During Stage one of the inspection, resident #001 was identified as having altered skin integrity.

A review of the resident's progress notes by Inspector #577 identified that resident #001 was admitted in October 2016, with altered skin integrity. A physician order dated October 2016, instructed staff to provide a special skin treatment.

Inspector #577 reviewed the resident's "Skin/Wound Assessment" completed in October 2016, when they were admitted. This assessment identified altered skin integrity. The next skin assessment was dated January 2017.

A review of the progress notes identified skin assessments on one day in October 2016, one day in November 2016, and two days in January 2017.

A review of resident #001's current care plan indicated altered skin integrity, with the following interventions:

-apply treatment as ordered by physician
-weekly Wound and Skin Assessment to be completed every Wednesday or with dressing change.

A review of the home’s policy titled "Skin Care and Wound Management Program" revised date May 2, 2016, indicated the following:

-each resident who exhibits skin breakdown and/or wounds shall be assessed each week or more frequently, if needed, by a member of the registered nursing staff
-all skin assessments are documented in the progress notes

Inspector #577 conducted an interview with RN #102 in January 2016, and together reviewed the Treatment Administration Records (TARS), progress notes and the Wound/Skin Assessments for resident #001. RN #102 confirmed that the documentation was inconsistent and the Wound/Skin Assessments should have been completed weekly.

During an interview with Best Practice Clinician #103, they reported that staff were required to document an assessment in the progress notes weekly. They further confirmed that the Wound/Skin Assessment form was the home’s clinical tool that was utilized to assist staff with their documentation.

During an interview with Clinical Manager #104, they reported that staff were required to be documenting an assessment in the progress notes weekly. They further reported that the Wound/Skin Assessment form was the home's clinical tool, but they were not clear on the frequency of staff documentation on the tool. Inspector #577 and Clinical Manager #104 reviewed together the progress notes, TARS and the Wound/Skin Assessment form and they confirmed that the assessments were not completed weekly and documentation was inconsistent. [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 residents exhibiting altered skin integrity, including pressure ulcers are reassessed at least weekly by a member of the registered nursing staff, specifically in regards to resident #001, to be implemented voluntarily.

WN #2: 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.

On three days in January 2017, Inspectors #577, #616 and #617 made observations of resident rooms in disrepair, as follows:

-one room had a hole in the wall by the bathroom door frame, six inches in length and four inches in height; gouges on the wall in the bathroom and a hole in the bathroom wall that measured 16 inches in length and four inches in height
-one room had seven inches of metal exposed on the bottom corner of the bathroom door frame
-one room had three gouges in the wall by the residents headboard, five inches in height and two inches in length; four inches of exposed metal at door frame entry, at ankle level
-one room had a hole in the wall corner by the bathroom, five inches in height and two inches in length.

On January 17, 2017, Inspector #577 and ESM #105 attended those resident rooms together and observed holes and gouges in the walls and exposed metal at door frames. ESM #105 confirmed the damage to the walls in those resident rooms. [s. 15. (2) (c)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

During an interview with the Residents' Council president on January 16, 2016, they stated to Inspector #616 that the home had not responded to concerns raised at council meetings, in writing, within 10 days.

In a record review of the last three monthly council meeting minutes from October, November, and December 2016, the Inspector noted concerns had been raised at the December 15, 2016, meeting related to:
-mirrors in the closet organizers;
-missing clothing;
-a shower room with an offensive odour; and
-infection control practices by staff.

In addition to the record of these concerns in the council minutes, the Inspector found these same concerns had been documented on separate forms titled "Resident's Council Suggestions/Concerns", dated December 15, 2016. For each of the above identified concerns, the "Response/Action Taken" had also been documented on this same day, by the responsible department staff.

The Inspector reviewed the home's procedure titled, "Residents' Council", last revised June 15, 2016. Within the procedure, it was identified that the Therapeutic Recreationist obtained recommendations from the residents through Residents' Council, completed Resident Council Suggestion forms, and forwarded the recommendations to the Section Supervisor responsible for the outcome with a copy to the Administrator. The Administrator was to ensure that a response was provided to the Resident Council within 10 days of receipt.

During an interview with the Recreation and Volunteer Services Supervisor #100 on January 18, 2016, they stated to the Inspector that the home's action/response to concerns raised at a previous council meeting would have been brought back to the council at the next scheduled meeting, or they would have followed up with the specific resident who had voiced the concern, and documented their follow up in the resident's individual electronic health record.

During an interview with the Administrator that same day, the Inspector reviewed the home's "Residents' Council" procedure, and the Administrator stated this was the most current procedure. They further explained that they had signed off on the concerns identified from the December 15, 2016, Residents' Council meeting and had assumed that the responses had been provided to the council.

Together with the Inspector, the Administrator reviewed the contents of the Resident Council communication board in a main corridor. The minutes from the December meeting were posted, however, the responses to the concerns raised at this meeting were not. The Administrator stated that there was no alternate location that the responses would have been posted.

The Administrator verified to the Inspector that there was no record of written responses to the Council within 10 days related to the concerns identified at the December 15, 2016, meeting. [s. 57. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council and the Family Council, if any was sought, in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with Residents' Council president on January 16, 2016, they stated to Inspector #616 that the home had not sought the advice of the council, in developing and carrying out the survey, and in acting on its results.

The Inspector conducted a focused record review of the council minutes for 2016, related to the satisfaction survey. There was no documentation regarding the engagement of the council in survey development and implementation.

During an interview with the Recreation and Volunteer Services Supervisor #100, on January 18, 2016, the Inspector reviewed the contents of the Residents' Council record. They verified to the Inspector that there was no record that the council had been involved in the development of the survey.

Later that same day, the Inspector met with the Administrator, who verified they had completed a record review and could not verify that the advice from Residents' Council had been sought by the home for the development and carrying out of the satisfaction survey. [s. 85. (3)]

WN #5: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Director was to be informed of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, to have made a report in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A Critical Incident System (CIS) report was submitted to the Director in February 2016, related to staff discovery of a narcotic medication that reportedly appeared to have been tampered with.

Inspector #616 reviewed the CIS report as well as the home's record related to this incident. The outcome of the incident was not identified.

During an interview with the Director of Care on January 13, 2017, they stated to the Inspector that the outcome of this incident, whether or not the home determined that the narcotic medication ampules had been tampered with, had not been included in the outcome. [s. 107. (4) 3.]

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Issued on this 26th day of January, 2017

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

Original report signed by the inspector.