Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 21, 2020	2020_703625_0002	000978-20	Other

Licensee/Titulaire de permis

The Corporation of the City of Thunder Bay
Office of the City Clerk 500 Donald St. East THUNDER BAY ON P7E 5V3

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

Pioneer Ridge
750 Tungsten Street THUNDER BAY ON P7A 5C2

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

KATHERINE BARCA (625), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): January 27 to 31, 2020.

The intake #000978-20 was inspected upon during this Sudbury Service Area Office initiated inspection.

Critical Incident System (CIS) inspection #2020_703625_0003 was conducted concurrently with this Sudbury Service Area Office initiated inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Clinical Managers, the Best Practice Clinician, the Education Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Environmental Services Supervisor, a Maintenance employee, a Public Health Nurse, residents and their families.

The Inspectors also conducted daily tours of resident care areas, conducted observations of shared residential areas and of residents' rooms, observed the provision of care and services to residents, observed staff-to-resident interactions, and interactions between and among residents. The Inspectors also reviewed resident health care records, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 VPC(s)**
- **4 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	Légende 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, with respect to residents #008, #009 and #010.

(a) Inspector #625 reviewed resident #008's health care record and was not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the resident's altered skin integrity on a specific location on their body.

During an interview with RPN #111, they were not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the resident's altered skin integrity on a specific location on their body.

(b) Inspector #625 reviewed resident #009's health care record and was not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the altered skin integrity on a specific location on the resident's body.

During an interview with RPN #111, they were not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the altered skin integrity on a specific location on the resident's body.

(c) Inspector #625 reviewed resident #010's health care record and was not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the altered skin integrity on a specific location on the resident's body.

During interviews with RPNs #112 and #113, they stated that the home had no assessment documents used by staff to complete initial wound assessments.

During an interview with the Best Practice Clinician #114, they stated that the home did not have a clinical assessment instrument that staff were required to complete for initial wound assessments. The Best Practice Clinician stated that that the home had a hard copy of a previously used assessment the staff could use, at their discretion, as a reference guide on what to include in a wound assessment.

During an interview with the DOC, they stated that the home did not have a clinically appropriate assessment instrument, specifically designed for skin and wound assessments, that staff completed for initial wound assessments. The DOC stated that staff were required to document their "assessments" in the progress notes and, although the staff could use a reference document as an assessment guide, completion of the guide was not a mandatory requirement. [s. 50. (2) (b) (i)]

2. 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, with respect to residents #008, #009 and #010.

The home's policy titled "Skin Care and Wound Management Program", revised December 2018, identified that each resident who exhibited skin breakdown and/or wounds was to be assessed each week or more frequently, if needed, by a member of the registered nursing staff, and that all skin assessments were to be documented in the progress notes.

(a) Inspector #625 reviewed resident #008's health care record from a particular date in 2019, to a particular date in 2020, and was not able to locate weekly reassessments of the resident's altered skin integrity on a specific location on their body. The Inspector could only identify progress notes, dated a particular date in 2019, and a particular date in 2020, which contained documentation related to some aspects of wound assessment. Neither entry contained assessment information identified in a Wound/Skin Assessment guide provided by the home, such as the date of onset of the wound, the status of the periwound skin, information of the wound base tissue type, dressings used, length/width/depth of the wound, undermining/tunneling, odour, or presence of pain.

During an interview with RPN #111, they stated that they worked where resident #008 resided and had completed dressing changes for the resident. The RPN was not able to locate weekly wound assessments completed for the resident's altered skin integrity on a specific location of their body. The RPN stated they had never completed a weekly wound assessment for the altered skin integrity.

During an interview with the Best Practice Clinician #114, they reviewed resident #008's progress notes from a particular date in 2019, to a particular date in 2020, and stated that weekly assessments of the resident's altered skin integrity had not been completed and, of the few entries that had been completed, they were not adequate to encompass a weekly wound assessment.

(b) Inspector #625 reviewed resident #009's health care record from a particular date in 2019, to a particular date in 2020, and was not able to locate weekly reassessments of the resident's altered skin integrity on a specific location on the resident's body. The Inspector noted that "assessment" of the altered skin integrity on resident #009's specific body part, documented in the progress notes, did not occur over a period of 12 days in 2020. In addition, multiple entries did not contain assessment information identified in a Wound/Skin Assessment guide provided by the home, such as the date of onset of the wound, the status of the periwound skin, information of the wound base tissue type, presence of exudate (including amount and colour), dressings used, length/width/depth of the wound, undermining/tunneling, odour, or presence of pain. The Inspector also noted that throughout 23 dates in 2019, the progress notes identified the wound as located on one area of the resident's body, while throughout 29 dates in 2020, it was identified as located on another area of the resident's body.

During an interview with Best Practice Clinician #114, they reviewed resident #009's progress notes from a particular date in 2019, to a particular date in 2020, and stated

that weekly assessments of the altered skin integrity on the specific area of the resident's body had been completed weekly during some weeks, but didn't include all of the necessary information expected to be included in the progress notes.

(c) Inspector #625 reviewed resident #010's health care record from a particular date in 2019, to a particular date in 2020, and was not able to locate weekly reassessments of the resident's altered skin integrity on a specific location on their body. The Inspector noted that "assessment" of altered skin integrity on the specific location on their body, documented in the progress notes, did not occur over a period of 14 days in 2019; over another period of 13 days in 2019; over a period of 10 days in 2020; or over another period of 17 days in 2020. None of the entries contained assessment information identified in a "Wound/Skin Assessment" guide provided by the home, such as the date of onset of the wound, the status of the periwound skin, information of the wound base tissue type, presence of exudate (including amount and colour), dressings used, length/width/depth of the wound, undermining/tunneling, odour, or the presence of pain.

During an interview with the Best Practice Clinician #114, they reviewed resident #010's progress notes from a particular date in 2019, to a particular date in 2020, and stated that the resident had only two weekly skin assessment entries entered in one month in 2020. The Best Practice Clinician also stated that some entries identified the altered skin integrity was present, but did not include the size or appearance of the altered skin integrity, and that the assessments that were completed were done poorly and were incomplete. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 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.

Inspector #196 reviewed the home's policy titled, "Medication Management – Overview", revised December 2018, which indicated that "All controlled substances shall be stored in a separate, double-locked cupboard/drawer in the medication room or within the medication cart".

The Inspector also reviewed the pharmacy service provider's policy titled "Medication Storage in the Facility - 3.7" (undated). The policy indicated the following:
- "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";
- "Medication storage areas, rooms, and carts are kept locked";
- "All medication carts must be secured, in a locked area, when not in use"; and
- "Unless in use, cart and narcotic lock box must remain locked at all times".

(a) On a date in 2020, at a particular time, Inspector #196 observed two unlocked medication carts in the medication room on one of the plazas. Controlled substances were locked in the bottom drawer of the unlocked carts.

During an interview with RPN #123, they confirmed that the medication carts within the medication rooms should probably be locked.

(b) On another date in 2020, Inspector #196 observed a white metal cupboard on the wall in the medication room on another plaza. RPN #103 reported that this cupboard was used to store narcotics when RPN #104 was working.

During an interview with RPN #104, they confirmed their use of the cupboard during their shift; demonstrated the single lock on the cupboard; and showed the Inspector the controlled substances held within. They reported that they had told the manager that the cupboard was only under a single lock.

During an interview with the DOC, they confirmed that the cupboard on the wall in the medication room on that plaza had a single lock on it. The DOC confirmed to the Inspector that the home's policy was not followed in relation to the requirement for a double locked cupboard within the medication room for storage of controlled drugs.

(c) On a date in 2020, Inspector #625 observed two medication carts on a plaza stored inside the medication room. The medication room door was opened and RPN #110 was seated at a computer at the nursing station. Both medication carts were unlocked, and both contained locked narcotics boxes.

During an interview with RPN #110, they stated that they had the keys to both medication carts and acknowledged that both carts were unlocked, with locked narcotics boxes inside. The RPN stated they did not lock the medication carts when they were kept in the medication room, and would keep the unlocked medication carts in the locked medication room if not using them, because the medication room door locked. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Infection Prevention and Control Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During completion of the "LTCH Licensee Confirmation Checklist Infection Prevention and Control", the home had difficulty identifying relevant evidence-based practice documents upon which resident and/or staff screening for infectious diseases and immunization practices were based.

(a) Resident Tuberculosis (TB) Screening:
Inspector #625 reviewed the home's final version of the completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the Public Health Ontario report titled "Tuberculosis screening on admission to long-term care homes in Ontario" dated May 2019, was listed as the home's reference for direction on TB screening.

The Inspector reviewed meeting minutes for the home's Infection Control Advisory Committee, dated June 10, 2019, which included a section titled "TB Skin Test Policy", and indicated the home would continue with TB skin testing for new admissions, as per their policy. It identified Public Health Ontario had an "updated policy posted in May 2019", and nursing administration would review and decide on policy changes for the home.

The Inspector also reviewed the meeting minutes for the home's Infection Control Advisory Committee, dated December 9, 2019, which included a section titled "TB Skin Test Policy", which identified "Problems with commitment to having chest x-rays upon admission. Pioneer Ridge will continue with their regular procedure."

The Inspector reviewed the home's current policy titled "Tuberculosis Screening –

Residents", revised December 2018. The home's policy detailed TB screening for residents new to the home using TB skin tests. The policy identified references for the policy as "PIDAC Routine Practices and Additional Precautions in All Health Care Settings and related Annexes". The policy did not cite the document "Tuberculosis screening on admission to long-term care homes in Ontario", dated May 2019, although it had been listed as a reference upon which resident TB screening was based, on the "LTCH Licensee Confirmation Checklist Infection Prevention and Control" completed by the home.

The Inspector reviewed the document titled "PIDAC Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition", revised November 2012, listed as a reference for the home's policy "Tuberculosis Screening – Residents". The document did not contain guidelines for general screening of residents for TB, including the information on TB skin testing contained in the home's policy.

The Inspector reviewed the Provincial Infectious Diseases Advisory Committee's (PIDAC) "Annex A - Screening, Testing and Surveillance for Antibiotic-Resistant Organisms (AROs) In All Health Care Settings", revised February 2013; "Annex B - Best Practices for Prevention of Transmission of Acute Respiratory Infection", revised March 2013; and "Annex C - Testing, Surveillance and Management of Clostridium difficile In All Health Care Settings", revised January 2013. None of the documents pertained to TB and none contained guidelines for general screening of residents for TB, including the information on TB skin testing contained in the home's policy.

During an interview with the DOC, they stated that the home had discussed the document "Tuberculosis screening on admission to long-term care homes in Ontario", dated May 2019, during Professional Advisory Committee meetings. The DOC stated the home had determined it would not implement the recommendation in the document, for residents 65 years and older to have chest x-rays upon admission, due to difficulties the residents would experience during transport off-site.

(b) Staff Immunization Program:
(i) The Inspector reviewed the home's completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the home identified staff were "offered and highly encouraged to receive annual influenza" as the immunization offered to staff in the home. The home identified that the evidence-based practice, or if there were none, the prevailing practice the staff immunization program was based on was the "Public Health Agency of Canada (2009) Tuberculosis

prevention and control; Canadian Tuberculosis Standard 7th Edition 2014" and the "Canadian Immunization Guide – provide current recommendations for vaccines of people of all ages".

On January 29, 2020, during an interview with the DOC, the Inspector asked about this response, as the home had responded that it offered only the influenza vaccine, not any other immunizations which the Canadian Immunization Guide would recommend; and the question did not pertain to TB, as staff TB screening was addressed in a separate question. The DOC then crossed out the previous response listed, and wrote "Public Health Unit" as the response to the question.

However, on January 27, 2020, during an interview with the Thunder Bay District Health Unit (TBDHU) Public Health Nurse #118, in the presence of the DOC, the Public Health Nurse assigned as the liaison to the home for the last two years, had stated that the TBDHU staff had been provided with no direction from their management to give the home any direction to change practices in the homes, or to have those discussions with the home, with respect to the staff immunization program.

(ii) The Inspector reviewed the home's completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the home's response to evidence-based practices for staff screening for infectious diseases [other than TB] was directly relevant to the question on the checklist regarding the staff immunization program in the home. The home had responded "Upon Hiring, staff are questioned with a statement of fitness at which time, the importance of up to date immunization is discussed. Immunization records or any health-related documents submitted, are collected by corporate employee health nurse, Any areas of concern on any documentation provided is communicated with hiring supervisor." The Inspector noted that this response was contradictory to information the DOC and Administrator had provided during interviews, when they had stated that the home did not have a staff immunization program, other than offering staff the influenza vaccine annually; and when the DOC had commented that the corporate employee health nurse did not have a role in the staff immunization program for the home, specifically with respect to new staff.

The Inspector reviewed the home's policy titled "Immunization – Residents and Staff", revised December 2018, that identified that the home was to maintain a staff immunization program in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. The policy referenced only influenza

immunization related to staff. The policy cited “PIDAC Routine Practices and Additional Precautions in All Health Care Settings and related Annexes” as references for the policy.

The Inspector reviewed “PIDAC Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition”, revised November 2012. The document identified that “Specific requirements for certain health care and residential facilities may be found in the Regulation for Health Care and Residential Facilities… Under that regulation there are a number of requirements, including: Requirements for an employer to establish written measures and procedures for the health and safety of workers…Such measures and procedures may include, but are not limited to, the following: … immunization and inoculation against infectious diseases.” The document specifically addressed staff immunization identifying “Health care providers must be offered appropriate immunizations… Vaccines appropriate for susceptible health care providers include:
- annual influenza vaccine
- measles, mumps, rubella (MMR) vaccine
- varicella vaccine
- hepatitis B vaccine, which should be followed by serology to document immunity
- acellular pertussis vaccine
- meningococcal vaccine for medical laboratory technologists who handle live meningococcal cultures
- tetanus/diphtheria”.

The Inspector reviewed the Provincial Infectious Diseases Advisory Committee's (PIDAC) "Annex A - Screening, Testing and Surveillance for Antibiotic-Resistant Organisms (AROs) In All Health Care Settings", revised February 2013, and "Annex C - Testing, Surveillance and Management of Clostridium difficile In All Health Care Settings", revised January 2013. Neither document contained information on staff immunizations, including the information contained in the home's policy.

The Inspector also reviewed "Annex B - Best Practices for Prevention of Transmission of Acute Respiratory Infection", revised March 2013. The document contained one section titled "Health Care Worker (HCW) Immunization", which provided direction related to influenza and pertussis vaccines, and contained four specific recommendations for HCW immunizations, including the recommendation that "All adults, including health care workers, should receive one dose of tetanus/ diphtheria/ acellular pertussis (Tdap) vaccine".

During interviews with the DOC, they confirmed that they did not discuss staff immunization status with staff upon hire, and did not require staff to provide evidence of their immunization status. The DOC stated that the corporate employee health nurse had not had a role in the staff immunization program, specifically with respect to newly hired staff.

During an interview with the Administrator, they stated that the home offered influenza vaccines annually to staff. The Administrator stated the home did no screening for staff immunizations in other areas, including upon hire. The Administrator stated the home would have to revise its staff immunization program as, after research, they had identified that it was recommended that health care workers be assessed for immunization for tetanus, diptheria, etc.

(c) Staff Screening for Infection Diseases:
The Inspector reviewed the home’s completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the home’s response for other screening done for staff for infectious diseases [excluding TB], done in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, included “Staff annually review the outbreak management policy and staff exclusion policy and during high outbreak times must provided list of symptoms with onset and severity”.

Inspector #625 reviewed the home’s policy titled “Outbreak Management”, revised December 2018. The policy identified that the DOC/designate would inform the Ministry of Health and Long-Term Care Compliance Advisor and provide a final summary report. The Inspector noted that, although the “Compliance Advisor” role had been eliminated in 2010, when the Long-Term Care Homes Act, 2007, came into effect, the home’s current policy, revised December 2018, continued to refer to the Compliance Advisor position. The Inspector also identified that the current method for reporting an outbreak to the Director, in accordance with Ontario Regulation 79/10, s. 107 (1) 5, as identified in the Reporting Requirements Tip Sheet provided to long-term care homes on February 15, 2019, [immediately by submitting a CIS report Monday to Friday from 0830 hours to 1630 hours; or after hours using the After-Hours Line and submitting a CIS report the next business day] was not reflected in the policy.

(d) Pet Immunizations:
During an initial attempt to complete the "LTCH Licensee Confirmation Checklist Infection Prevention and Control", the home had referred to the home’s pet visitation policy, which

had been attached to the checklist.

The home's policy titled "Pet Visits – Registered Program", revised December 2018, identified that the pet visitors must have completed the volunteer screening process as per volunteer policies, and identified criteria the pet must meet to visit. The policy did not indicate the pets required up-to-date immunizations.

During an interview with the Administrator, they stated that pets involved in the home's formal pet therapy visitation program should be current in their immunizations, and that the home's policy would need to be revised to reflect this. The Administrator stated that some residents' family members brought in pets for programming, and the home would need to ensure its pet visitation program was current in that all pets involved in pet

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, could be easily seen, accessed and used by residents, staff and visitors at all times.

The home's policy titled, "Call Bells and Call Phone System", last revised December 2018, indicated "As per the LTCHA, all residents at Pioneer Ridge Long Term Care and Senior Services will have access to a functioning call bell to summon assistance when needed."

(a) During observations of resident #003's room, the call bell did not activate when pressed by Inspector #196.

The Inspector asked a PSW to check this call bell and to determine why it was not working. They demonstrated that the call bell was detached from the wall and was not working. The PSW then attached the connections and the call bell activated when pressed.

(b) Further observations, during a tour of the home, identified that one of the plaza's left side resident living room, and another plaza's right side resident living room did not have a cord attached to the call bell units on the wall.

During an interview, RPN #108 confirmed to the Inspector that that the call bell in their resident living room was not operational as it did not have a cord.

During an interview with the Environmental Manager, they confirmed that the resident living rooms required a cord that attached to the call bell in order to activate the call bell system. [s. 17. (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 that ensures that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, with respect to positioning resident #001 using their assistive device and applying a specific component of that device.

Inspector #625 observed resident #001 using an assistive device with a specific component of the that device in place. The Inspector noted that the one side of the component of the device was positioned unsafely with respect to the assistive device and the resident's body. In addition, another characteristic of the component of the device was unsafely applied.

During an interview with RPN #116, they stated the component of resident #001's assistive device was not correctly applied, and that it should not be positioned in relation to the resident's body as it was. The RPN determined that it was caught on part of the assistive device which caused it to be positioned differently on the resident's body.

During an interview with the Best Practice Clinician #114, they stated that the component of resident #001's assistive device was unsafely positioned on one side as it was caught in another part of the assistive device and came up over one part of the resident's body, but should come up over another part of the resident's body.

During an interview with Clinical Manager #117, they identified that the component of

resident's assistive device was caught on another part of their assistive device which caused the component to come up over one specific part of the resident's body instead of another specific part of their body. The Clinical Manager stated that the component was not safely positioned and should be positioned without being caught in other components of the assistive device. [s. 36.]

2. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, with respect to positioning resident #005 using their assistive device and applying a specific component of that device.

Inspector #625 observed resident #005 using an assistive device with a specific component of that device in place. The Inspector noted that the component of the device was positioned in a specific manner, in relation to the resident's body. One side of the component of the assistive device was not applied correctly, and was not present in the manner expected, but was present in a different manner.

During an interview with the Best Practice Clinician #114, they stated that the component of resident #005's assistive device demonstrated a specific characteristic and was not safely positioned. The Best Practice Clinician attempted to correct the unsafe characteristic of the component and stated that it was incorrectly attached in place and could not be corrected as it was. They then adjusted the component so that a portion of the device was used as intended; following which, they adjusted the component twice, until it was appropriately positioned with respect to the resident's body. [s. 36.]

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 that ensures that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident, with respect to the level of assistance resident #001 required with a specific activity of daily living at the time of a fall.

Inspector #625 reviewed a hand-written note containing the name of one resident who fell in 2020, provided by Best Practice Clinician #114. The note identified that resident #001 fell, was transferred to hospital, and sustained injuries.

Inspector #625 reviewed resident #001's health care record including:
- a progress note dated a specific date in 2020, that identified staff responded to noise from the hallway and found resident #001 on the floor; and
- the care plan in place at the time of the fall, effective a date in 2019, that included an intervention created by RPN #108, identifying the resident required a specific level of assistance with an activity of daily living. The care plan also identified the resident did not require assistance with other activities of daily living.

The Inspector also reviewed pictures from a video of the fall, that showed the fall happened near a room on the unit.

During an interview with RPN #108, they stated that, at the time of resident #001's fall, they had not required the level of assistance specified in the care plan with an activity of daily living. The RPN stated the resident had not needed assistance with the specific activity of daily living, but had required an alternate type of assistance.

During an interview with the DOC, they stated that resident #001 had not required staff assistance with a specific activity of daily living. The DOC stated they did not know why the resident's care plan in place at the time of their fall identified the resident had required staff assistance, as the resident had not required assistance with a specific activity of daily living at the time of their fall. [s. 6. (2)]

WN #7: 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 all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

During a tour of the home, Inspector #196 identified the following doors leading to non-residential areas were unlocked and unsupervised by staff:
- The linen room door and the clean utility room door on a specific plaza were unlocked and not supervised by staff. During interviews, RPN #108 and RPN #124 both confirmed these doors needed to be locked; and
- The door to the clean utility room on another plaza was unlocked and unsupervised by staff. During an interview, RPN #125 confirmed to the Inspector that this was a non-residential area and the door must be kept locked.

On the following day, the same linen room door was again unlocked and not supervised by staff. During an interview, Clinical Manager #102 confirmed to the Inspector that this door should be locked at all times and that it was a non-residential area.

During an interview with the Environmental Services Manager, they confirmed to the Inspector that non-residential areas and utility rooms were to be closed and locked when not in use. [s. 9. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.

During a tour of the home by Inspector #196, a window on a specific plaza, in the resident lounge was noted to open greater than 15 centimetres (cm).

In an interview, RPN #124 confirmed to the Inspector that this window in the resident lounge could open all the way and was not to open that much.

During an interview with Maintenance employee #126, they reported that the window should not open more than an amount they demonstrated with their fingers, and then said they were going to fix the one that was noted to open wide.

During an interview, the Environmental Services Supervisor told the Inspector that it was expected that all windows did not open greater than 15 cm as was within the legislation. [s. 16.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance, with respect to the safe positioning of resident #002.

The home's policy titled "Pleasurable Dining Enhancement", revised December 2018, indicated that "All dining rooms will be furnished with appropriate furniture and equipment including comfortable dining room tables and dining room chairs that are an appropriate height for residents to eat and for staff assisting residents to eat"; "Adequate space is provided in the dining room to maneuver wheelchairs and walkers"; and "Staff will provide personal assistance and encouragement when needed as well as ensure residents are positioned in a safe manner (wheel chair foot rests and hips at 90 or slightly less) while assisting resident's to eat."

On a date during the inspection, during observations of the dining room on a specific plaza by Inspector #196, resident #002 was using an assistive device with a specific characteristic while at a dining table feeding themself their meal. The resident was sitting upright while the assistive device in a particular position, and their arm was stretched out all the way to reach their food. At this same dining table, there were additional residents using various types of the assistive device, one visitor and two PSWs seated on stools assisting the residents.

During an interview, PSW #105 reported that resident #002 did not normally sit at this table, they usually sat at another table at the other end of the dining room, and they didn't know why they were seated at this table at this time. The PSW then acknowledged that the resident had to reach forward to get to the food on their plate; the PSW attempted to reposition the assistive device without result and was unable to move the assistive device as needed as there was no place for a component of the assistive device, because of space.

During an interview, RPN #106 confirmed to the Inspector, that resident #002 did not look comfortable while using their assistive device.

During an interview, RPN #107 reported to the Inspector that resident #002 was seated at a different table; they were usually seated at another table at another location in the dining room with another resident. RPN #107 confirmed to the Inspector that there was not enough room for this resident to be seated at this current table; they couldn't position

the assistive device as needed; the assistive device couldn’t be positioned in a required manner; and the resident had to lean forward to reach for their food. [s. 73. (1) 10.]

Issued on this 27th day of May, 2020

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHERINE BARCA (625), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2020_703625_0002
Log No. / No de registre :	000978-20
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	May 21, 2020
Licensee / Titulaire de permis :	The Corporation of the City of Thunder Bay Office of the City Clerk, 500 Donald St. East, THUNDER BAY, ON, P7E-5V3
LTC Home / Foyer de SLD :	Pioneer Ridge 750 Tungsten Street, THUNDER BAY, ON, P7A-5C2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lee Mesic

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50 (2) of Ontario Regulation 79/10.

Specifically, the licensee must:
(a) Develop and implement a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
(b) Ensure that residents #008, #009 and #010, and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, with respect to residents #008, #009 and #010.

(a) Inspector #625 reviewed resident #008's health care record and was not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the resident's altered skin integrity on a specific location on their body.

During an interview with RPN #111, they were not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the resident's altered skin integrity on a specific location on their body.

(b) Inspector #625 reviewed resident #009's health care record and was not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the altered skin integrity on a specific location on the resident's body.

During an interview with RPN #111, they were not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument

that was specifically designed for skin and wound assessment, for the altered skin integrity on a specific location on the resident's body.

(c) Inspector #625 reviewed resident #010's health care record and was not able to locate an initial skin assessment completed, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, for the altered skin integrity on a specific location on the resident's body.

During interviews with RPNs #112 and #113, they stated that the home had no assessment documents used by staff to complete initial wound assessments.

During an interview with the Best Practice Clinician #114, they stated that the home did not have a clinical assessment instrument that staff were required to complete for initial wound assessments. The Best Practice Clinician stated that that the home had a hard copy of a previously used assessment the staff could use, at their discretion, as a reference guide on what to include in a wound assessment.

During an interview with the DOC, they stated that the home did not have a clinically appropriate assessment instrument, specifically designed for skin and wound assessments, that staff completed for initial wound assessments. The DOC stated that staff were required to document their "assessments" in the progress notes and, although the staff could use a reference document as an assessment guide, completion of the guide was not a mandatory requirement.

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual risk for harm to occur, and the scope, which indicated that the non-compliance was widespread. In addition, the home's compliance history identified a history of non-compliance specific to this subsection of the legislation as follows:
- a Voluntary Plan of Correction (VPC) was issued from RQI inspection #2017_624196_0020. (625)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 21, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50 (2) of Ontario Regulation 79/10.

Specifically, the licensee must:
(a) Ensure that residents #008, #009 and #010, and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

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, with respect to residents #008, #009 and #010.

The home's policy titled "Skin Care and Wound Management Program", revised December 2018, identified that each resident who exhibited skin breakdown and/or wounds was to be assessed each week or more frequently, if needed, by a member of the registered nursing staff, and that all skin assessments were to be documented in the progress notes.

(a) Inspector #625 reviewed resident #008's health care record from a particular date in 2019, to a particular date in 2020, and was not able to locate weekly reassessments of the resident's altered skin integrity on a specific location on their body. The Inspector could only identify progress notes, dated a particular date in 2019, and a particular date in 2020, which contained documentation related to some aspects of wound assessment. Neither entry contained assessment information identified in a Wound/Skin Assessment guide provided by the home, such as the date of onset of the wound, the status of the periwound skin, information of the wound base tissue type, dressings used, length/width/depth of the wound, undermining/tunneling, odour, or presence of pain.

During an interview with RPN #111, they stated that they worked where resident #008 resided and had completed dressing changes for the resident. The RPN was not able to locate weekly wound assessments completed for the resident's altered skin integrity on a specific location of their body. The RPN stated they had never completed a weekly wound assessment for the altered skin integrity.

During an interview with the Best Practice Clinician #114, they reviewed resident #008's progress notes from a particular date in 2019, to a particular date in 2020, and stated that weekly assessments of the resident's altered skin integrity had not been completed and, of the few entries that had been completed, they were not adequate to encompass a weekly wound assessment.

(b) Inspector #625 reviewed resident #009's health care record from a particular date in 2019, to a particular date in 2020, and was not able to locate weekly reassessments of the resident's altered skin integrity on a specific location on the resident's body. The Inspector noted that "assessment" of the altered skin integrity on resident #009's specific body part, documented in the progress notes, did not occur over a period of 12 days in 2020. In addition, multiple entries did not contain assessment information identified in a Wound/Skin Assessment guide provided by the home, such as the date of onset of the wound, the status of the periwound skin, information of the wound base tissue type, presence of exudate (including amount and colour), dressings used, length/width/depth of the wound, undermining/tunneling, odour, or presence of pain. The Inspector also noted that throughout 23 dates in 2019, the progress notes identified the wound as located on one area of the resident's body, while throughout 29 dates in 2020, it was identified as located on another area of the resident's body.

During an interview with Best Practice Clinician #114, they reviewed resident #009's progress notes from a particular date in 2019, to a particular date in 2020, and stated that weekly assessments of the altered skin integrity on the specific area of the resident's body had been completed weekly during some weeks, but didn't include all of the necessary information expected to be included in the progress notes.

(c) Inspector #625 reviewed resident #010's health care record from a particular date in 2019, to a particular date in 2020, and was not able to locate weekly reassessments of the resident's altered skin integrity on a specific location on their body. The Inspector noted that "assessment" of altered skin integrity on the specific location on their body, documented in the progress notes, did not occur over a period of 14 days in 2019; over another period of 13 days in 2019; over a period of 10 days in 2020; or over another period of 17 days in 2020. None of

the entries contained assessment information identified in a "Wound/Skin Assessment" guide provided by the home, such as the date of onset of the wound, the status of the periwound skin, information of the wound base tissue type, presence of exudate (including amount and colour), dressings used, length/width/depth of the wound, undermining/tunneling, odour, or the presence of pain.

During an interview with the Best Practice Clinician #114, they reviewed resident #010's progress notes from a particular date in 2019, to a particular date in 2020, and stated that the resident had only two weekly skin assessment entries entered in one month in 2020. The Best Practice Clinician also stated that some entries identified the altered skin integrity was present, but did not include the size or appearance of the altered skin integrity, and that the assessments that were completed were done poorly and were incomplete.

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual risk for harm to occur, and the scope, which indicated that the non-compliance was widespread. In addition, the home's compliance history identified a history of non-compliance specific to this subsection of the legislation as follows:
- a Voluntary Plan of Correction (VPC) was issued from RQI inspection #2017_624196_0020. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 21, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(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).

Order / Ordre :

The licensee must be compliant with s. 129 (1) of Ontario Regulation 79/10.

Specifically, the licensee must:
(a) Ensure that 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.

Grounds / Motifs :

1. 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.

Inspector #196 reviewed the home's policy titled, "Medication Management – Overview", revised December 2018, which indicated that "All controlled substances shall be stored in a separate, double-locked cupboard/drawer in the medication room or within the medication cart".

The Inspector also reviewed the pharmacy service provider's policy titled "Medication Storage in the Facility - 3.7" (undated). The policy indicated the following:
- "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";
- "Medication storage areas, rooms, and carts are kept locked";
- "All medication carts must be secured, in a locked area, when not in use"; and
- "Unless in use, cart and narcotic lock box must remain locked at all times".

(a) On a date in 2020, at a particular time, Inspector #196 observed two unlocked medication carts in the medication room on one of the plazas. Controlled substances were locked in the bottom drawer of the unlocked carts.

During an interview with RPN #123, they confirmed that the medication carts within the medication rooms should probably be locked.

(b) On another date in 2020, Inspector #196 observed a white metal cupboard on the wall in the medication room on another plaza. RPN #103 reported that this cupboard was used to store narcotics when RPN #104 was working.

During an interview with RPN #104, they confirmed their use of the cupboard during their shift; demonstrated the single lock on the cupboard; and showed the Inspector the controlled substances held within. They reported that they had told the manager that the cupboard was only under a single lock.

During an interview with the DOC, they confirmed that the cupboard on the wall in the medication room on that plaza had a single lock on it. The DOC confirmed to the Inspector that the home's policy was not followed in relation to the requirement for a double locked cupboard within the medication room for storage of controlled drugs.

(c) On a date in 2020, Inspector #625 observed two medication carts on a plaza stored inside the medication room. The medication room door was opened and RPN #110 was seated at a computer at the nursing station. Both medication carts were unlocked, and both contained locked narcotics boxes.

During an interview with RPN #110, they stated that they had the keys to both medication carts and acknowledged that both carts were unlocked, with locked narcotics boxes inside. The RPN stated they did not lock the medication carts when they were kept in the medication room, and would keep the unlocked medication carts in the locked medication room if not using them, because the medication room door locked.

The decision to issue a Compliance Order (CO) was based on the severity which indicated minimal risk for harm to occur, and the scope, which indicated that the non-compliance was widespread. In addition, the home's compliance history identified a history of non-compliance specific to this subsection of the legislation as follows:
- a Written Notification (WN) was issued from Complaint inspection #2019_507742_0005. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 02, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee must be compliant with s. 229 (2) of Ontario Regulation 79/10.

Specifically, the licensee must:
(a) Ensure that the home's infection prevention and control (IPAC) program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
(b) Review the home's current policies pertaining to the IPAC program, with emphasis on resident screening for tuberculosis (TB); resident immunizations including influenza, pneumococcus, tetanus and diphtheria; staff screening for TB and other infectious diseases; the staff immunization program; and pet immunizations for pets living in the home or visiting as part of a pet visitation program.
(c) Update the policies to ensure they are in compliance with O. Reg. 79/10, s. 229 (10) and s. 229 (12).
(d) Update the policies to ensure they are in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
(e) Maintain a record of the evidence-based or prevailing practice documents upon which the policies have been evaluated and updated.
(f) Maintain copies of the policies in place prior to the review and update.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Infection Prevention and Control Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During completion of the "LTCH Licensee Confirmation Checklist Infection Prevention and Control", the home had difficulty identifying relevant evidence-based practice documents upon which resident and/or staff screening for infectious diseases and immunization practices were based.

(a) Resident Tuberculosis (TB) Screening:
Inspector #625 reviewed the home's final version of the completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the Public Health Ontario report titled "Tuberculosis screening on admission to long-term care homes in Ontario" dated May 2019, was listed as the home's reference for direction on TB

screening.

The Inspector reviewed meeting minutes for the home's Infection Control Advisory Committee, dated June 10, 2019, which included a section titled "TB Skin Test Policy", and indicated the home would continue with TB skin testing for new admissions, as per their policy. It identified Public Health Ontario had an "updated policy posted in May 2019", and nursing administration would review and decide on policy changes for the home.

The Inspector also reviewed the meeting minutes for the home's Infection Control Advisory Committee, dated December 9, 2019, which included a section titled "TB Skin Test Policy", which identified "Problems with commitment to having chest x-rays upon admission. Pioneer Ridge will continue with their regular procedure."

The Inspector reviewed the home's current policy titled "Tuberculosis Screening – Residents", revised December 2018. The home's policy detailed TB screening for residents new to the home using TB skin tests. The policy identified references for the policy as "PIDAC Routine Practices and Additional Precautions in All Health Care Settings and related Annexes". The policy did not cite the document "Tuberculosis screening on admission to long-term care homes in Ontario", dated May 2019, although it had been listed as a reference upon which resident TB screening was based, on the "LTCH Licensee Confirmation Checklist Infection Prevention and Control" completed by the home.

The Inspector reviewed the document titled "PIDAC Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition", revised November 2012, listed as a reference for the home's policy "Tuberculosis Screening – Residents". The document did not contain guidelines for general screening of residents for TB, including the information on TB skin testing contained in the home's policy.

The Inspector reviewed the Provincial Infectious Diseases Advisory Committee's (PIDAC) "Annex A - Screening, Testing and Surveillance for Antibiotic-Resistant Organisms (AROs) In All Health Care Settings", revised February 2013; "Annex B - Best Practices for Prevention of Transmission of Acute Respiratory

Infection", revised March 2013; and "Annex C - Testing, Surveillance and Management of Clostridium difficile In All Health Care Settings", revised January 2013. None of the documents pertained to TB and none contained guidelines for general screening of residents for TB, including the information on TB skin testing contained in the home's policy.

During an interview with the DOC, they stated that the home had discussed the document "Tuberculosis screening on admission to long-term care homes in Ontario", dated May 2019, during Professional Advisory Committee meetings. The DOC stated the home had determined it would not implement the recommendation in the document, for residents 65 years and older to have chest x-rays upon admission, due to difficulties the residents would experience during transport off-site.

(b) Staff Immunization Program:
(i) The Inspector reviewed the home's completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the home identified staff were "offered and highly encouraged to receive annual influenza" as the immunization offered to staff in the home. The home identified that the evidence-based practice, or if there were none, the prevailing practice the staff immunization program was based on was the "Public Health Agency of Canada (2009) Tuberculosis prevention and control; Canadian Tuberculosis Standard 7th Edition 2014" and the "Canadian Immunization Guide – provide current recommendations for vaccines of people of all ages".

On January 29, 2020, during an interview with the DOC, the Inspector asked about this response, as the home had responded that it offered only the influenza vaccine, not any other immunizations which the Canadian Immunization Guide would recommend; and the question did not pertain to TB, as staff TB screening was addressed in a separate question. The DOC then crossed out the previous response listed, and wrote "Public Health Unit" as the response to the question.

However, on January 27, 2020, during an interview with the Thunder Bay District Health Unit (TBDHU) Public Health Nurse #118, in the presence of the DOC, the Public Health Nurse assigned as the liaison to the home for the last two years,

had stated that the TBDHU staff had been provided with no direction from their management to give the home any direction to change practices in the homes, or to have those discussions with the home, with respect to the staff immunization program.

(ii) The Inspector reviewed the home's completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the home's response to evidence-based practices for staff screening for infectious diseases [other than TB] was directly relevant to the question on the checklist regarding the staff immunization program in the home. The home had responded "Upon Hiring, staff are questioned with a statement of fitness at which time, the importance of up to date immunization is discussed. Immunization records or any health-related documents submitted, are collected by corporate employee health nurse, Any areas of concern on any documentation provided is communicated with hiring supervisor." The Inspector noted that this response was contradictory to information the DOC and Administrator had provided during interviews, when they had stated that the home did not have a staff immunization program, other than offering staff the influenza vaccine annually; and when the DOC had commented that the corporate employee health nurse did not have a role in the staff immunization program for the home, specifically with respect to new staff.

The Inspector reviewed the home's policy titled "Immunization – Residents and Staff", revised December 2018, that identified that the home was to maintain a staff immunization program in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. The policy referenced only influenza immunization related to staff. The policy cited "PIDAC Routine Practices and Additional Precautions in All Health Care Settings and related Annexes" as references for the policy.

The Inspector reviewed "PIDAC Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition", revised November 2012. The document identified that "Specific requirements for certain health care and residential facilities may be found in the Regulation for Health Care and Residential Facilities… Under that regulation there are a number of requirements, including: Requirements for an employer to establish written measures and procedures for the health and safety of workers…Such measures and procedures may include,

but are not limited to, the following: … immunization and inoculation against infectious diseases." The document specifically addressed staff immunization identifying "Health care providers must be offered appropriate immunizations… Vaccines appropriate for susceptible health care providers include:
- annual influenza vaccine
- measles, mumps, rubella (MMR) vaccine
- varicella vaccine
- hepatitis B vaccine, which should be followed by serology to document immunity
- acellular pertussis vaccine
- meningococcal vaccine for medical laboratory technologists who handle live meningococcal cultures
- tetanus/diphtheria".

The Inspector reviewed the Provincial Infectious Diseases Advisory Committee's (PIDAC) "Annex A - Screening, Testing and Surveillance for Antibiotic-Resistant Organisms (AROs) In All Health Care Settings", revised February 2013, and "Annex C - Testing, Surveillance and Management of Clostridium difficile In All Health Care Settings", revised January 2013. Neither document contained information on staff immunizations, including the information contained in the home's policy.

The Inspector also reviewed "Annex B - Best Practices for Prevention of Transmission of Acute Respiratory Infection", revised March 2013. The document contained one section titled "Health Care Worker (HCW) Immunization", which provided direction related to influenza and pertussis vaccines, and contained four specific recommendations for HCW immunizations, including the recommendation that "All adults, including health care workers, should receive one dose of tetanus/ diphtheria/ acellular pertussis (Tdap) vaccine".

During interviews with the DOC, they confirmed that they did not discuss staff immunization status with staff upon hire, and did not require staff to provide evidence of their immunization status. The DOC stated that the corporate employee health nurse had not had a role in the staff immunization program, specifically with respect to newly hired staff.

During an interview with the Administrator, they stated that the home offered influenza vaccines annually to staff. The Administrator stated the home did no screening for staff immunizations in other areas, including upon hire. The Administrator stated the home would have to revise its staff immunization program as, after research, they had identified that it was recommended that health care workers be assessed for immunization for tetanus, diptheria, etc.

(c) Staff Screening for Infection Diseases:
The Inspector reviewed the home's completed "LTCH Licensee Confirmation Checklist Infection Prevention and Control", dated January 29, 2020. The Inspector noted that the home's response for other screening done for staff for infectious diseases [excluding TB], done in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, included "Staff annually review the outbreak management policy and staff exclusion policy and during high outbreak times must provided list of symptoms with onset and severity".

Inspector #625 reviewed the home's policy titled "Outbreak Management", revised December 2018. The policy identified that the DOC/designate would inform the Ministry of Health and Long-Term Care Compliance Advisor and provide a final summary report. The Inspector noted that, although the "Compliance Advisor" role had been eliminated in 2010, when the Long-Term Care Homes Act, 2007, came into effect, the home's current policy, revised December 2018, continued to refer to the Compliance Advisor position. The Inspector also identified that the current method for reporting an outbreak to the Director, in accordance with Ontario Regulation 79/10, s. 107 (1) 5, as identified in the Reporting Requirements Tip Sheet provided to long-term care homes on February 15, 2019, [immediately by submitting a CIS report Monday to Friday from 0830 hours to 1630 hours; or after hours using the After-Hours Line and submitting a CIS report the next business day] was not reflected in the policy.

(d) Pet Immunizations:
During an initial attempt to complete the "LTCH Licensee Confirmation Checklist Infection Prevention and Control", the home had referred to the home's pet visitation policy, which had been attached to the checklist.

The home's policy titled "Pet Visits – Registered Program", revised December

2018, identified that the pet visitors must have completed the volunteer screening process as per volunteer policies, and identified criteria the pet must meet to visit. The policy did not indicate the pets required up-to-date immunizations.

During an interview with the Administrator, they stated that pets involved in the home's formal pet therapy visitation program should be current in their immunizations, and that the home's policy would need to be revised to reflect this. The Administrator stated that some residents' family members brought in pets for programming, and the home would need to ensure its pet visitation program was current in that all pets involved in pet visitation programs had up-to-date vaccines.

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual risk for harm to occur. Although the home did not have a compliance history specific to this section of the legislation, the scope indicated that the non-compliance was widespread. (625)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katherine Barca

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