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_0003	001356-20	Critical Incident System

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 a Critical Incident System inspection.

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

The following intake was inspected upon during this Critical Incident System (CIS) inspection:
- log #001356-20 related to CIS report #M599-000002-20, regarding alleged resident abuse.

Sudbury Service Area Office initiated inspection #2020_703625_0002 was conducted concurrently with this CIS 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), residents and their families.

The Inspectors also conducted daily tours of resident care areas, 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, an investigation file, relevant portions of employee files, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with, with respect to an incident of alleged abuse that occurred in 2019, involving resident #002.

Inspector #196 reviewed a Critical Incident System (CIS) report submitted to the Director on a date in 2020, for an incident of alleged abuse of resident #002 by a staff member. The report identified the incident had occurred on or about a date 20 days prior, that PSW #120 had witnessed the alleged abuse at the time of the occurrence, and that the home’s administration had not been notified of the incident until the date the CIS report was submitted. The report also indicated that an investigation into the incident occurred when management was notified of the incident.

Inspector #196 reviewed the home's policy titled, "Abuse and Neglect", revised December 2018, which indicated "A person having knowledge of alleged/suspected or witnessed abuse or neglect must immediately report it to their direct supervisor and the RN in charge". The policy also identified that registered staff were required to provide immediate care and ensure the safety and well-being of the resident victim and collaborate in completing a physical assessment of the resident victim. The RN would report the alleged/suspected or witnessed abuse or neglect immediately to the Director of Nursing (DON)/Designate or Administrator. The home’s policy titled, “Mandatory Reporting", revised December 2018, indicated “On becoming aware of alleged, suspected or witnessed abuse or neglect of a resident, report immediately to your supervisor and the RN on duty” and “The RN will inform the Director of Nursing or designate…”.

The home's investigation file was reviewed. There was a handwritten letter dated the date the CIS report was submitted to the Director, signed by RN #121, which identified that a message was left for the DOC regarding the incident at the time it was reported to them, on the previous date. The file included a letter that was issued to PSW #120 and specified the PSW had failed to report the suspected abuse of a resident at the time of occurrence, which was a violation of Homes for the Aged Procedure 'Abusive Behaviour - Staff to Residents' and the Ministry of Health and Long Term Care 'Resident Bill of Rights'".

During an interview, the DOC reported that PSW #120 should have reported the incident of alleged abuse immediately to the RN when it had occurred. The DOC confirmed that PSW #120 had not complied with the home’s policy on zero tolerance of abuse and neglect. The DOC also reported that they had not been informed of the incident until the

day after it was reported to RN #121, as the RN had either left a message or sent an email to inform administration of the allegation, which resulted in the investigation beginning the day following the date the RN became aware of it, in 2020. [s. 20. (1)]

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, without in any way restricting the generality of the duty provided for in section 19, there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of resident #002 by PSW #119, that resulted in harm or a risk of harm to the resident occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director on a date in 2020, for an incident of alleged abuse of resident #002 by a staff member which had occurred on or about a date 20 days prior. The report indicated that, while providing care, PSW #120 witnessed PSW #119 abuse resident #002 during an episode of responsive behaviours. The report also identified that the home's management commenced an investigation into the alleged incident as soon as they had been notified.

Ontario Regulation (O. Reg.) 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Inspector #196 reviewed the home's policy titled, "Abuse and Neglect", revised December 2018, which indicated that "A person having knowledge of alleged/suspected or witnessed abuse or neglect must immediately report it to their direct supervisor and the RN in charge." Another home's policy titled, "Mandatory Reporting", revised December 2018, stated that "any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director; 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident". The policy also read, "On becoming aware of alleged, suspected or witnessed abuse or neglect of a resident, report immediately to your supervisor and the RN on duty"; "The RN will inform the Director of Nursing or designate and the Administrator and complete a Resident Incident Report and a Critical Incident Report as required"; and "An immediate investigation will begin and the information collected will be disclosed to the Director".

During an interview, the DOC reported that the home's investigation had determined that the incident had occurred on a date in 2019. They stated that PSW #120 first reported the incident on a specific date in 2020, to another PSW, and then subsequently to RN #121. The RN had then left a message or sent an email to the DOC on the date they were notified by the PSW, to notify them of an incident of alleged abuse. The DOC said the CIS report was submitted to the Director, by the home's Administrator, the following day, when management were notified of the incident of alleged abuse towards resident #002 by a staff member. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, including resident #002, strategies were developed and implemented to respond to these behaviours, where possible.

Inspector #196 reviewed a CIS report submitted to the Director on a date in 2020, for an incident of alleged abuse of a resident by a staff member, which had occurred on or about a date 20 days prior. The report indicated, while providing care, PSW #120 alleged that they witnessed PSW #119 abuse resident #002 during an episode of responsive behaviours.

The health care records for resident #002 were reviewed. The care plan in effect at the time of the incident included interventions detailing how staff were to respond to specific responsive behaviours. The progress notes entered by PSW #119 indicated that the resident had exhibited specific responsive behaviours, but did not reflect that the PSW had responded as directed in the care plan.

The employee file for PSW #119 was reviewed. A letter indicated that PSW #119 had reacted to the resident's responsive behaviour by responding in a certain manner to the resident; and the PSW's response and actions to deal with an episode of the resident’s responsive behaviour were not consistent with the home’s "Gentle Persuasion Approach" to care or the interventions outlined in the residents plan of care to deal with the behaviour.

During an interview with PSW #119, they reported to the Inspector that, in the situation, they had responded in a specific manner. They further reported they couldn’t act in a specific manner to the resident for safety reasons.

During an interview with the Administrator, they reported to the Inspector that they did not feel the incident was abuse; PSW #119's approach should have been to follow interventions listed in the care plan; and they exhibited a characteristic towards the resident that was not what would be expected. They further added they weren’t comfortable that PSW #119 responded in a particular manner and they did not follow the resident’s plan of care, which indicated they should have responded in a different manner. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

Issued on this 1st day of June, 2020

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

Original report signed by the inspector.