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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 8, 2020 | 2020_740621_0008 | 004110-20 | 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

JULIE KUORIKOSKI (621)

### 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): June 1 - 2, 2020.**

**The following intake was inspected during this Critical Incident System (CIS) inspection:**
**- One intake related to falls prevention and management.**

**During the course of the inspection, the inspector(s) spoke with a Clinical Manager (CM), the Physiotherapist (PT), Physiotherapist Aides (PTAs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Nursing Unit Support Worker (NUSW), a Storeskeeper, and a resident.**

**The Inspector also reviewed relevant resident health care records, an internal incident and investigation report, as well as specific licensee policies, procedures, and programs.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 was reassessed and that plan of care reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary.

A Critical Incident System (CIS) report was received by the Director on a day in March 2020, for a fall of resident #001 with injury. The CIS report identified that resident #001 returned from hospital on a later date in March 2020, and as part of their plan of care, required the use of of a medical device, a specified number of safety devices, and physiotherapy services.

During an interview of resident #001, Inspector #621 observed the resident in their mobility aide, with a specific safety device activated and in place, along with another safety device observed in a certain location of the resident's living space. The resident was also observed not to be utilizing a specific medical device, and able to locomote independently with their mobility aide.

During a review of resident #001's most current care plan, last updated in June 2020, the Inspector found no information identifying that a certain number of safety devices were to be utilized. Additionally, a specific focus of the care plan identified that a specific medical device was to be discontinued on a specified date in March 2020. However, under another focus of the care plan, it continued to identify that the resident was to utilize the medical device and continue to have certain physical limits with respect to their injury.

During an interview with PSW #100, they reported to the Inspector that for safety and alerting staff to resident #001's potential attempts to complete certain activities on their own, that use of a particular number of safety devices continued to be part of their plan of care. Additionally, PSW #001 stated that the resident no longer required the use of a certain medical device, and no longer required the physical limits imposed, with respect to their injury. On review of resident #001's most current care plan, PSW #001 confirmed to the Inspector that the identified safety devices were not included as interventions within any care plan focus. Additionally, PSW #001 confirmed that under a specified focus, direction was received to discontinue use of a certain medical device on a specific day in March 2020, yet another focus of the care plan continued to identify that the resident was to wear the identified medical device and have certain physical limits with respect to their injury. Finally, on review of the resident's care plan, PSW #001 also reported that within a specified number of care plan foci, it continued to identify that the

resident was to utilize a specific number and types of incontinence products during a particular time of day, when the resident now only wore another specific type of incontinence product over a specified time frame. Together with the Inspector, PSW#001 observed a supply of only the current type of incontinence product being used in resident #001's washroom.

During an interview with Stores Worker #109, they reported that home area staff had submitted continence product change request forms following resident #001's incident, and that time of inspection, a specific number and type of incontinence products were no longer a part of the resident's incontinence care product requirements.

During an interview with PTA #108, they reported to the Inspector that resident #001 attended physiotherapy programming over specific time intervals, for specified activities. They also reported that the resident no longer required use of a specified medical device. On review of resident #001's physiotherapy care plan, PTA #108 confirmed that a certain number of care interventions were not documented as part of resident #001's most current physiotherapy program, and should have been.

During an interview with PTA #108, they reported that since the onset of the pandemic, they have been required to work off-site, and had been unable to access and update resident #001's care plan on the home's electronic medical record (EMR), to include the additional program interventions currently implemented with the resident, as part of their physiotherapy plan of care.

During an interview with Clinical Manager #104, they reported that it was their expectation that PSW staff informed the RPN on duty of any changes required to a resident's care plan to maintain currency. On review of resident #001's most current care plan with the Inspector, including requisite observations, Clinical Manager #104 confirmed that the resident's care plan had not been revised to reflect their current care needs with respect to use of a certain number and type of safety devices, continence product requirements, and discontinuation of therapies including a certain medical device. Additionally, Clinical Manager #104 identified that, to maintain currency of the Physiotherapy care plan when the PT was unable to access the EMR off-site, it was their expectation that the PT notified the RPN on duty, to ensure that updates to the resident's physiotherapy care plan could be made on their behalf. [s. 6. (10) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001 is reassessed and that plan of care is reviewed at least every six months, and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**Issued on this 9th day of June, 2020**

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

**Original report signed by the inspector.**