Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 8, 2014	2014_320576_0005	S-000054-14	Critical Incident System

Licensee/Titulaire de permis

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

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

PIONEER RIDGE
750 TUNGSTEN STREET, THUNDER BAY, ON, P7B-6R1

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

MARSHA RIVERS (576)

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): May 26, 27, 28, 2014.

This inspection was conducted concurrently with Inspection #2014_320576_0006.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Best Practice Clinician, registered staff, Personal Support Workers, and a resident's substitute decision maker.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas, reviewed resident health care records, reviewed the home's policy to promote zero tolerance of abuse and neglect of residents, and reviewed the home's programs for falls prevention and responsive behaviours.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. Inspector #576 reviewed a Critical Incident Report submitted by the home for a resident to resident abuse incident and health care records for resident #01 and resident #02. Inspector noted that resident #01 and resident #02 shared a room for approximately 1 month in 2014. In the reported abuse incident, staff witnessed through a surveillance camera resident #02 "fly forceably backwards" out of the shared room and into the hall. When questioned by staff, resident #01 stated that he/she pushed resident #02 out of the room. As a result of the altercation, resident #02 sustained a fracture requiring surgical intervention. The Critical Incident Report was submitted by the home 7 days following the abuse incident. The Administrator confirmed that this incident of resident to resident abuse that resulted in harm to a resident was not immediately reported to the Director.

The licensee failed to ensure that the abuse of a resident by anyone that resulted in harm was immediately reported to the Director. [s. 24. (1)]

2. Inspector #576 reviewed the health care records for resident #03 for a period of approximately 5 months in 2013 and 2014. Inspector noted that during this period, resident #03 was involved in numerous physical and verbal altercations with other residents. Staff #112 stated that resident #03 was physically aggressive with many residents, but seemed to target specific residents, including resident #04 and resident #05.

Inspector reviewed the health care records for resident #03 and resident #04 for a period of approximately 5 months in 2013 and 2014. Inspector noted that during this period, resident #03 and resident #04 were involved in 3 altercations. In the first incident, resident #03 scratched resident #04, and resident #04 pushed resident #03 to the floor. As a result of this altercation, resident #04 sustained 3 skin tears. In the second incident, resident #04 pushed resident #03 to the floor. As a result of this altercation, resident #03 sustained a 1 cm scratch. In the third incident, resident #03 grabbed the hand of resident #04 using his/her fingernails. As a result of this incident, resident #04 sustained a skin tear and bruising. Inspector reviewed the Critical Incident System reports submitted by the home and noted that the home did not report these incidents of abuse to the Director.

Inspector reviewed the health care records for resident #03 and resident #05 for a period of approximately 5 months in 2013 and 2014. Inspector noted that during this period, resident #03 and resident #05 were involved in 2 altercations. In the first incident, resident #03 pinched the arm of resident #05 and resident #05 stated that the pinch hurt. In the second incident, resident #03 pinched the arm of resident #05. As a result of this altercation, resident #05 sustained 3 small bruises. Inspector reviewed the Critical Incident System reports submitted by the home and noted that the home did not report these incidents of abuse to the Director. The Administrator confirmed the home does not report incidents of resident to resident abuse resulting in what the home considers to be minor injuries, such as bruises, skin tears, or scratches.

The licensee failed to ensure that the abuse of a resident by anyone that resulted in harm or risk of harm was immediately reported to the Director. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. Inspector #576 reviewed the Critical Incident System report submitted by the home for a resident to resident abuse incident and health care records for resident #01 and resident #02. Inspector noted that resident #01 and resident #02 shared a room for approximately 1 month in 2014. During this period, resident #01 and resident #02 were involved in 2 altercations. In the first incident, resident #01 and resident #02 were involved in a physical altercation whereby resident #01 was observed to hit resident #02 in the chest, and resident #02 was observed to have struck resident #01 on the head several times. In the second incident, staff witnessed through a surveillance camera resident #02 "fly forceably backwards" out of the shared room and into the hall. When questioned by staff, resident #01 stated that he/she pushed resident #02 out of the room. As a result of the altercation, resident #02 sustained a fracture requiring surgical intervention. The plan of care for resident #01 and resident #02 was not updated following their first altercation, to identify factors that could potentially trigger altercations and interventions to minimize the risk of further altercations between resident #01 and resident #02.

The licensee failed to identify and implement interventions to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54. (b)]

Issued on this 28th day of July, 2014

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