Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2016	2016_463616_0009	007728-16	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

JENNIFER KOSS (616)

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): April 6, 7, 8, 2016

Complaint inspection #2016_463616_0008 and Follow Up inspection #2016_463616_0010 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (AD), Director of Nursing (DON), Clinical Managers, Registered Dietitian (RD), RAI Coordinator, Personal Support Workers (PSW), Best Practice Coordinator, family members and residents.

Observations were made of the home areas, and the provision of care and services to residents during the inspection. Many of the home's policies and procedures, and resident health records were reviewed.

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.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted including the right to participate fully in the development, implementation, review and revision of their plan of care.

A Critical Incident (CI) report was submitted to the Director by the home in March 2016, related to an allegation of staff to resident abuse. The report alleged that PSW #100 treated resident #001 roughly during care, and threatened the resident that they would leave if the resident would not comply with their way of care.

A documented interview with the resident was reviewed in the home's investigation record. The resident had reported to the Director of Nursing (DON) that PSW #100 had disregarded the care planned instruction and direction provided by the resident, causing pain to the resident.

During an interview with resident #001, they reported to Inspector #616, that they had been involved in the detailed development of their care plan. They added this information was available for staff reference. According to the resident, the staff assigned to their care this day had indicated they were unfamiliar with the resident's plan of care, and did not listen to the resident during the task.

During an interview with the DON, they stated to the Inspector that the resident's right to participate in the implementation of their plan of care had not been fully respected. [s. 3. (1) 11. i.]

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 the following rights of residents are fully respected and promoted: 11. Every resident has the right to, i. participate fully in the development, implementation, review and revision of his or her plan of care, to be implemented voluntarily.

WN #2: 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 a written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident (CI) report was submitted to the Director by the home in March 2016, related to an allegation of staff to resident abuse that occurred 2 days prior. However, the home had reported the incident to the Ministry of Health and Long-Term Care "after hours pager" nearly 12 hours after the incident had occurred and upon the DON becoming aware of it. The report identified that PSW #100 allegedly treated resident #001 roughly during morning care.

Inspector #616 reviewed the home's investigation record related to this incident. The investigation identified that PSW #101, PSW #103, and RPN #102 had been aware of the resident's report of alleged rough treatment by PSW #100 and had not immediately reported it to a supervisor.

The home's policy titled "Abuse and Neglect", last revised October 2015, stated that anyone who has reasonable grounds to suspect any of the following has a duty to report their suspicion immediately to their supervisor or administrator: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

During an interview with the DON, they stated that the three staff had knowledge of the resident's report of abuse and they did not immediately report it but they should have. [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 to 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, to be implemented voluntarily.

Issued on this 13th day of June, 2016

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

Original report signed by the inspector.