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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 15, 2019	2019_507742_0005	000840-19, 000861-19	Complaint

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

SHARON GOERTZEN (742), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 25 - February 28, 2019.

Two complaints related to abuse and neglect were inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Resident Assessment Instrument (RAI) Coordinator, Clinical Manager, Housekeeping Staff, and a Financial Clerk.

The Inspectors also observed staff to resident interactions, observed provision of care and services to residents, reviewed relevant health records, as well as licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **6 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary; and that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Inspector #742 observed resident #001's equipment to be soiled on three consecutive days during various times of the day.

On the third consecutive day, Housekeeper #106 was asked to observe resident #001's equipment and acknowledged that it was soiled. Housekeeper #106 was able to remove the soilage with a disinfectant wipe.

On two consecutive days, resident #008's equipment was observed to have a stain on it in which housekeeper #106 was unable to remove the stain with a disinfectant wipe. In an interview with housekeeper #106, they acknowledged that the equipment did not appear to be in a good state of repair.

On one occasion, resident #009's equipment was observed to be soiled. Housekeeper #106 was asked by Inspector #625 and Inspector #742 to observe resident #009's equipment; they confirmed it was soiled and should have been cleaned with a disinfectant wipe.

In an interview with Personal Support Worker (PSW) #105, they acknowledged that they had provided care for resident #009 and were aware of the soiled equipment; they were distracted with another demand and forgot to return to clean it. PSW #105 confirmed that care staff were to clean body fluids on equipment with a disinfectant wipe when it was noticed, and they were not to leave it.

The review of the home's procedural manual titled "Basins, Bedpans, Urinals, and Commodes (Daily Cleaning)," stated that housekeeping staff would clean emptied and rinsed basins, bedpans, urinals and commodes that were not visibly soiled with body fluids. Nursing staff were responsible for cleaning off any body fluids.

Director of Care (DOC) #103 observed resident #008's equipment and confirmed that is was not in a good state of repair and that it would be replaced. The DOC also observed a photograph of resident #009's equipment when it was soiled, they confirmed that it was soiled and should have been cleaned as soon as it was noticed by the staff member who assisted the resident. [s. 15. (2) (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 to ensure that the home, furnishings and equipment are kept clean and sanitary; and that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the home's resident-staff communication system could be easily seen, accessed by residents, staff, and visitors at all times.

Inspector #742 and Inspector #625 observed that the resident-staff communication system was not easily accessible to one resident on multiple occasions.

A review of the home's policy titled,"Call Bells & Call Phone System," indicated as per the Long Term Care Health Act (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. The policy stated that it was the responsibility of all staff to ensure that the call bell was securely placed within reach of the resident while they were in their room. Placement of call bells were assessed during regular monitoring and rounds to ensure they were within reach of the resident.

Both Inspectors observed resident #010 on two separate occasions and noted that their resident-staff communication and response system was not easily accessible.

On the first occasion, the resident's communication and response system was observed to be laying on the floor, the cord was wrapped around the side rail closest to the window, and was not accessible to resident #010 who was lying in bed.

Registered Practical Nurse (RPN) #108 was requested to attend resident #010's room by both Inspectors, and acknowledged that the resident's communication and response system was on the floor and not accessible to the resident. RPN #108 placed the communication and response system on resident #010's bed, and said it should have been positioned in that manner for the resident to reach it, as they may need to use it.

On the second observation, resident #010 was observed laying in bed with their communication and response system wrapped around the left bed rail, underneath the resident's sheet/blanket.

In a review of resident #010's current care plan, it revealed interventions, which included ensuring that their resident-staff communication system was within reach.

Resident Assessment Instrument (RAI) Coordinator #114 was requested to attend resident #010's room by both Inspectors, and acknowledged that the resident-staff communication and response system was not accessible to the resident. [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 to ensure 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A Complaint report was submitted to the Director concerning alleged staff to resident neglect. The report indicated that resident #001 had asked a staff member to assist them with a specific care intervention on a particular shift in 2019. Resident #001 was told by the staff member that they would have to wait until morning for assistance with the specific intervention.

Within resident #001's care plan, the document indicated that the resident was required to be assisted with a specific care intervention by staff routinely. Additionally, the document contained interventions that advised staff that resident #001 required two staff members to assist them with the particular care intervention using a specific type of equipment. Resident #001 was to ring their call bell when they wanted to be assisted with the intervention.

Inspector #742 reviewed resident #001's care plan, which was updated following the incident of not being assisted with a particular care intervention by staff. The updated care plan indicated to staff that the resident required a specific care intervention on a particular shift, and that staff were to offer the intervention. If not effective, staff were to assist the resident using another intervention.

Further review of resident #001's current care plan, expected outcomes indicated that the resident was to establish a regular continence routine. Staff were to record continence outcomes every shift.

When reviewing resident #001's continence flow sheets, it was noted that continence outcomes were not recorded every shift in accordance with their care plan. Over a 17 day period in 2019, on 6 of 51 occasions, or 12 per cent of the time, continence outcomes were not recorded for resident #001. Additionally, over 25 days in 2019, on 25 of 75 occasions, or 33 per cent of the time, continence outcomes were not recorded.

During an interview with PSW #100, they acknowledged that it was the role of the PSW who was responsible for the resident's care, to document continence outcomes onto the resident's flow sheet every shift in accordance with their care plan. This included documenting the absence of continence outcomes every shift.

In the presence of Inspector #742, RPN #107 reviewed resident #001's care plan for two months in 2019, along with their flows sheets in which staff documented continence outcomes every shift. RPN #107 acknowledged that resident #001's flow sheets were not being recorded in accordance with the resident's care plan.

A review of the home's procedure manual under the title "Bladder & Bowel Management," indicated the following:
-"The plan of care must include individualized interventions, to maintain or promote continence, or comfort and skin maintenance if the resident is incontinent."
-"For residents who are continent, an individualized plan of care shall include a scheduled toileting plan."
-"Document the effectiveness and results of the interventions in the medication Administration Record(MAR), the Treatment Administration Record (TAR), and the resident's electronic record."
-"Communicate to the team and the resident's Substitute Decision Maker (SDM), anytime a change to the plan of care has occurred regarding continence management, as well as ongoing and at care conferences."

A review of the home's procedure manual, under the title "Personal Support Workers," indicated the following:
-"Respond promptly to resident's toileting needs."
-"Report effectiveness/results of any interventions, and any changes in the resident's bowel or bladder routines to the registered staff."
-"Document bladder and bowel functioning on the Flow Sheet and in the resident's electronic record."
-"Recognize and report resident verbalizations and behaviours indicative of a possible change in condition."

DOC #103 was requested to review resident #001's recent care plan along with their continence outcome flow sheets for a two month period in 2019. The DOC acknowledged that resident #001's continence portion of their care plan was not followed. [s. 51. (2) (b)]

2. A review of resident #004's care plan, revealed interventions which advised staff to record continence outcomes every shift and prn.

When reviewing resident #004's continence flow sheets over one month in 2019, it was noted that continence outcomes were not recorded every shift in accordance with their care plan. Over 17 days in a particular month, on 6 of 51 occasions, or 12 per cent of the time, continence outcomes were not recorded for resident #001. Additionally, over 25 days in a particular month, on 25 of 75 occasions, or 33 per cent of the time, continence outcomes were not recorded.

During an interview with RPN #107, they acknowledged that resident #004's continence outcome flow sheets were not being recorded in accordance with the resident's care plan.

During an interview with Registered Nurse (RN) #110, they acknowledged that resident #004's continence outcome flow sheets were not being recorded in accordance with the resident's care plan.

During an interview with DOC #103, they acknowledged that resident #004's continence portion of their care plan were not followed after they reviewed the continence outcome flow sheets and the resident's care plan. [s. 51. (2) (b)]

3. A review of resident #007's care plan, the interventions stated that staff were to

monitor continence outcomes, and record it on the resident's flow sheet.

When reviewing resident #007's continence outcome flow sheets over 25 days in 2019, it was noted that continence outcomes were not recorded every shift in accordance with their care plan. Over 25 days in a particular month, on 21 of 75 occasions, or 28 per cent of the time, continence outcomes were not recorded for resident #007.

During an interview with RPN #107, they acknowledged that resident #007's continence outcome flow sheets were not being recorded in accordance with the resident's care plan.

During an interview with RN #110, they acknowledged that resident #007's continence outcome flow sheets were not being recorded in accordance with the resident's care plan.

During an interview with DOC #103, they acknowledged that resident #007's continence portion of their care plan was not followed after they reviewed the continence management flow sheets and the resident's care plan. [s. 51. (2) (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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #4: 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 resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act.

Inspector #742 and Inspector #625 observed an open binder sitting on top of an unattended care cart in a main hallway. The binder displayed a listing of residents' names including their bath days. In a conversation with PSW #111, they acknowledged that the binder should not have been left open in a public area and that it was exposing personal health information of residents.

Inspector #742 and Inspector #625 observed a resident's electronic record displayed outside of a common area, unattended by staff. The electronic record displayed a particular resident's personal health information. RPN #102 acknowledged that personal health information was displayed on the monitor and could be seen by others. RPN #102 also acknowledged that this information should not have been displayed publicly.

Inspector #742 and Inspector #625 observed a resident's electronic record displayed outside of a resident's room unattended. RPN #107 came out of the resident's room to attend the electronic record and acknowledged that personal health information was displayed publicly on a particular resident. RPN #107 showed both Inspectors that they had found a button titled "hide details" that would remove personal health information from view.

In an interview with DOC #103, they acknowledged that staff should have been keeping electronic record information confidential.They confirmed that the home had started using a particular electronic record system several months ago. They also acknowledged that staff should have minimized the screen when leaving the electronic record unattended. The DOC stated they would ask Clinical Manager #113 to find the related policy, and follow up with staff to ensure personal health information was not revealed. [s. 3. (1) 11. iv.]

WN #5: 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 their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A Complaint report was submitted to the Director on a particular month in 2019. The report described that resident #001 had asked a staff member if they could be assisted with a specific care intervention on a specific shift in the winter of 2019. The resident was told by the staff member that they would have to wait until morning.

Within resident #001's care plan, it was noted that the resident was to have a specific care intervention carried out routinely by staff. The intervention portion of the care plan indicated that resident #001 would ring their call bell when they required the specific care intervention.

Within the home's procedural manual, under the title "Abuse and Neglect," it was defined that neglect was a failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being. The policy indicated that the home forbade any intentional form of abuse by any person interacting with residents and staff; this included verbal, psychological, sexual, neglect, or financial abuse.

During an interview with resident #001, they stated that they required the assistance of two staff for a specific care intervention. Resident #001 recalled on one occasion, that they had asked a staff member to assist them with a specific care intervention on a particular shift, and they were told to wait until the next morning. Resident #001 reported that they did wait, which resulted in an adverse outcome.

Within resident #001's progress notes on a specific day in 2019, it was documented that the SDM reported to RPN #117 a concern about the resident. They stated to RPN #117, that on a particular shift, that resident #001 rang their call bell and stated that they needed to be assisted with a a particular care intervention. They also stated that the

staff member replied saying the resident will have to wait until the morning. The SDM was very concerned to hear of this situation. RPN #117, recorded that they reassured the resident's SDM, and that the incident would be communicated to the staff; including an update of the resident's care plan.

In an interview with RPN #107, they acknowledged the conversation they had with the family member of resident #001 in regards to the resident being asked to wait until morning to receive assistance. They confirmed that they had updated resident #001's care plan so that it would state that if the resident required assistance during a specific shift, offer a specific intervention; if the intervention was not effective, assist the resident using another intervention. RPN #117 also reported this information to other staff members working that shift. The RPN also confirmed that they had documented the conversation with resident #001's SDM in their progress notes. RPN #117 acknowledged that they were aware of the home's policy on Abuse and Neglect and that they had annual training on it. RPN #117 acknowledged that they should have reported the conversation they had with resident #001's family to the RN or the DOC as per the home's policy.

In an Interview with DOC #103, they reported that they had received a phone call from resident #001's family member in regards to the incident as reported to RPN #117 previously. The DOC stated that this was the first they heard of the incident. DOC #103 then reported it to the Director and began investigating the incident. DOC #103 acknowledged that RPN #117 received coaching from management in regards to the home's process of reporting allegations to the management team.

DOC #103 acknowledged that through their investigation they determined that neglect did occur towards resident #001, and was not in accordance with the home's policy regarding the obligation to immediately report to their supervisor or Administrator. [s. 20. (1)]

WN #6: 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 drugs were stored in an area or a medication cart that was secure and locked.

a) On two separate days, Inspector #742 and Inspector #625 observed that a treatment cart was unlocked and was located in a main hallway of one of the care units unattended. On one of the occasions, the treatment medications were placed on top of the cart. On the second occasion, the same treatment cart was unlocked, and the treatment medications were stored in the cart unattended by staff outside of a resident's room.

Inspector #742 approached PSW #109 to discuss that the treatment cart appeared to be unlocked, unattended, and containing treatment medications. The PSW acknowledged that treatment medications should have been locked inside of the carts when unattended.

In a review of the home's Procedural Manual, revised November 15, 2018, titled "Medication Management;" the section titled - "Storage/Security" described that:
-all medications in the home were to be stored in an area that was secure, locked and complied with the manufacturer's instructions for the storage of drugs,
-all areas where medications were stored were to be kept locked at all times when not in use, and should only be accessed by those managing medications or performing administration duties.

b) On another occasion, Inspector #742 and Inspector #625 observed that a second treatment cart was unlocked and was located in a main hallway of one of the care units unattended. The treatment medications on the second cart were sitting in a basket on top of the cart.

In an interview with PSW #111, they acknowledged that treatment medications were sitting on top of the second treatment cart, but should have been stored inside of the cart and locked when unattended. [s. 129. (1) (a) (ii)]

Issued on this 19th day of March, 2019

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

Original report signed by the inspector.