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
Sep 23, 2020	2020_624196_0017	010317-20, 016235-20	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

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): Onsite August 6, 7, 10 - 13, 17 and 18 and offsite on August 27, 2020.

The following intakes were inspected in this Critical Incident System (CIS) inspection:
- one intake related to an after hours pager report regarding an alleged incident of staff to resident abuse; and
- one intake related to a CIS report regarding alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CMs), Best Practice Clinician Registered Nurse (BPC RN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

This inspection was conducted concurrently with Complaint inspection #2020_624196_0016 and Follow Up inspection #2020_624196_0018.

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not neglected by staff.

A Critical Incident System report was submitted to the Director for an incident of alleged staff to resident neglect.

The home's policy on zero tolerance of abuse and neglect and the LTCHA 2007, defined neglect as the, "Failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

In addition, the home's policy read, "There is 'Zero Tolerance' for abuse and /or neglect within the Corporation of the City of Thunder Bay and at Pioneer Ridge Long Term Care and Senior Services".

In an interview, the DOC confirmed that based upon the investigation, a resident was neglected by a PSW.

Sources: Review of CIS report, the home's abuse and neglect policy, relevant areas of a resident's health care record; interviews with the DOC and other staff. [s. 19. (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 resident is not neglected by staff, 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 the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

An after hours pager call was received by the MLTC regarding an incident of alleged staff to resident abuse. The call made by the DOC indicated that a resident alleged that a staff had physically abused them.

A Critical Incident System (CIS) report was not submitted to the Ministry of Long-Term Care (MLTC).

The home's policy titled, "Abuse and Neglect", indicated that, "Reporting and investigating all incidents promptly and thoroughly" was required. In addition, the policy indicated that a thorough investigation of the incident would be conducted and identified the required information to be gathered and from whom.

In an interview, the DOC reported that they had called the after hours pager with a report of the incident as they weren't sure if it was an allegation of staff to resident abuse.

In a further interview, the DOC reported to the inspector that they did not have records of their investigation.

In an interview, an RPN told the inspector about the incident involving this resident. They reported that a PSW had told them that this resident had been physically aggressive with them. Later, another PSW was accompanied by a PSW and reported to them that the PSW had physically abused this resident.

In an interview, an RN reported that someone had told them that the resident had been physically aggressive with a PSW. The RN then said they had spoken to a PSW and an RPN and it was reported that the PSW had been physically abusive with the resident. The RN then told the inspector that they had provided this information to the DOC and had asked them what they wanted them to do and the DOC then phoned the after hours number to report the incident.

In the interviews, all of the staff denied being interviewed by the DOC regarding the incident. The DOC was unable to specify what was done to determine that the resident was not abused by staff.

Sources: Review of the after hours pager report, the home's abuse and neglect policy, relevant areas of a resident's health care record, home's internal reports; interviews with the DOC, and other staff. [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 the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following material was included in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

An after hours pager call was received by the MLTC regarding an incident of alleged staff to resident abuse. The call made by the Director of Care (DOC) indicated that a resident alleged that a staff member had physically abused them.

A Critical Incident System (CIS) report was not submitted to the Ministry of Long-Term Care (MLTC).

The home's policy titled, "Abuse and Neglect", indicated that "The DON/Designate or Administrator will investigate all critical incident reports and notify the MOHLTC Inspection Branch, when determined as required, in accordance with the reporting requirements outlined in the LTCHA, 2007...". In addition, the policy read, "A thorough investigation of the incident will be conducted by the most appropriate supervisor and a written report will be prepared, containing the following information: What occurred, date and time of occurrence, who was involved, location of occurrence, names of those in the vicinity who may be witnesses, written statements from witnesses/residents (tape recorder may be used if required) and any other significant information pertaining to the investigation".

In an interview, the DOC reported that they had called the after hours pager with a report of the incident as they weren't sure if it was an allegation of staff to resident abuse.

Sources: Review of the after hours pager report, the home's abuse and neglect policy, relevant areas of the resident health care record, home's internal reports; interviews with the DOC, and other staff. [s. 104. (1) 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 report to the Director of alleged abuse of a resident, includes a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident, to be implemented voluntarily.

Issued on this 28th day of September, 2020

[redacted]

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

Original report signed by the inspector.