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
Jan 19, 2022	2022_884647_0002	013204-21	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

JENNIFER BROWN (647)

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): November 1 - 3, 2021

The following intake was inspected upon during this Critical Incident System (CIS) inspection:
-one log, related to alleged physical and verbal abuse.

Follow up inspection #2022_884647_0001 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Infection Prevention and Control (IPAC) lead, the Support Service Manager, Registered Nurses (RNs), Registered Practical Nurse (RPNS), Personal Support Workers (PSWs), Housekeeping staff, residents and family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed
staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

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)**
- **1 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. 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. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee was vicariously liable for staff members who failed to comply with subsection 24 (1).

A Critical Incident System (CIS) report was submitted to the Director, which alleged verbal and physical abuse of three resident's by a staff member, during care rounds.

During an interview with a PSW, they reported that they had witnessed the incident between another PSW and the identified residents, during care rounds, but did not report the incident to the Registered Nurse (RN), (who had been the RN on duty that shift), or Clinical Manager (CM) #101, until the next day.

During an interview with the CM, they indicated that in the morning of an identified day, they received an electronic mail (email) message from the PSW, and verified that the incident had occurred the day prior. Consequently, by the PSW failing to report the incident immediately, they confirmed that this resulted in the home's management being unable to report the incident to the Director, as per legislative requirements.

Sources: Review of home's internal investigation notes, CIS report, employee records; and interviews with a PSW, RN, CM, and other relevant staff. [s. 24. (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 a person who has reasonable grounds to suspect abuse of a resident, report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members who fail to comply with subsection 24 (1), to be implemented voluntarily.

WN #2: 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 three resident’s were protected from verbal and physical abuse.

Ontario Regulation (O. Reg.) 79/10, s. 2. (1), defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Additionally, and subject to subsection (2) of O. Reg 79/10, s. 2, physical abuse is defined as “the use of physical force by anyone other than a resident that causes physical injury”.

A CIS report was submitted to the Director, which identified that during care provided, on an identified day, a PSW witnessed another PSW provide care that was physically and verbally aggressive towards several residents.

A review of the home’s investigation notes, included electronic mail (email) from a PSW to the CM, which identified that a PSW had been verbally inappropriate to a resident, and aggressively rolled the resident as they responded with “ouch”. They reported that another resident responded with “ouch” also, as they had their blankets ripped off and aggressively rolled over. Finally, it was indicated that the PSW ripped the resident’s blankets off them, while aggressively provided care.

The PSW reported to the Inspector that the other PSW had been verbally and physically aggressive toward the identified residents after startling them out of a deep sleep, and that the PSW stated to them that “this is what we have to do to get the job done”.

An interview with the CM, and a review of the home’s investigation notes, including a letter of discipline from the home to the PSW, confirmed that the PSW was founded to have verbally and physically abused the residents identified.

Sources: Review of home’s internal investigation notes, CIS report, employee records; and interviews with two PSW's, an RN, a CM, and other relevant staff. [s. 19. (1)]

Issued on this 19th day of January, 2022

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

Original report signed by the inspector.