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
Mar 7, 2013	2012_211106_0007	527, 1271, 1273	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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 18, 19, 20, 2012

Log # S-000527-12, S-001271-12, S-001273-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Education Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. CIS report # M599-000018-12, submitted to the Director, identifies a resident to resident altercation between resident #004 and resident #003, where resident #003 later required transfer to hospital. The plan of care for resident #004 was reviewed and under the focus, "Behaviour Problem/mood state/ psychosocial well being", the following interventions were found, "Remove resident from person or situation contributing to behaviour"; "Identify patterns of behaviours over time to clarify underlying causes". These interventions do not provide clear direction to staff regarding, strategies staff might use once resident #004 is removed from the situation. The licensee failed to ensure that the plan of care has clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. CIS report # M599-000022-12, identifies that resident #003 fell and sustained an injury, when they were being assisted out of bed by their roommate. The plan of care for resident #003 contains an intervention guiding staff to, monitor closely when (#003) is with roommate and to discourage roommate assisting (#003) with transfers. During a December 20, 2012 interview staff member #S-100, reported that the resident is monitored hourly. The plan of care does not provide staff with clear direction as to how often to monitor the resident or provide strategies on how to discourage the roommate from assisting with transfers. The licensee failed to ensure that the plan of care has clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 plan of care for residents #003 and #004 have clear directions to staff and others who provide direct care to the residents, in regards strategies to be used when residents are exhibiting responsive behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. On December 18, 2012 at approximately 1132 h and on December 19, 2012 at approximately 1830 h resident # 005 was observed with both a front facing seat belt and a rear facing seat belt applied. On both occasions the rear facing belt was sitting high, in that it was placed up on the resident's and not snuggly around the resident's hips, where one would typically expect it to be positioned. The licensee failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 of the Act, staff apply the physical device in accordance with any manufacturer's instructions. [s. 110. (1) 1.]

2. On December 20, 2012 at approximately 1150 h resident # 006 was observed with both a front facing seat belt and a rear facing seat belt applied. The rear facing belt was loose and sitting high, in that it was placed up on the resident's chest and not placed snuggly around the resident's hips, where one would typically expect it to be positioned. The licensee failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 of the Act, staff apply the physical device in accordance with any manufacturer's instructions. [s. 110. (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 to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 of the Act, staff apply the physical device in accordance with any manufacturer's instructions, in regards to rear and front facing seat belts, to be implemented voluntarily.

WN #3: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On December 18, 2012 during lunch, inspector 106 observed resident # 003 in bed being fed by staff member # S-101. Inspector noted a dirty brief was on the floor beside the bed and feces were visible on brief. Staff member # S-101 was observed to walk near and partially over the brief while they were feeding the resident. It was also noted by the inspector that the room had an offensive odour of feces. The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity, was fully respected and promoted. [s. 3. (1) 1.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. On December 18, 2012 at approximately 1132 h and on December 19, 2012 at approximately 1830 h resident # 005 was observed with both a front facing seat belt and a rear facing seat belt applied. The restraint record for resident #005 was reviewed and it identified that in the month of December the resident had a restraint applied 16 of 19 days. The plan of care was reviewed for resident #005 on December 19, 2012 at approximately 1830 h, and no section in the plan of care regarding the use of a restraint was found. The licensee failed to ensure that a resident who may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. [s. 31. (1)]

2. On December 18, 2012 at approximately 1132 h and on December 19, 2012 at approximately 1830 h resident # 005 was observed with both a front facing seat belt and a rear facing seat belt applied. Progress note dated Dec 17, 2012, reviewed, identifies front belt to be used in interim until an appropriate rear facing belt is received received. A doctor's order for the rear facing belt was found, but no order for use of the front facing belt was found. Staff member # S-102 was asked to show the inspector the order for the front facing belt, they were unable to do so. The licensee failed to ensure that that restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. [s. 31. (2) 4.]

3. On December 18, 2012 at approximately 1132 h and on December 19, 2012 at approximately 1830 h resident # 005 was observed with both a front facing seat belt and a rear facing seat belt applied. Progress note dated Dec 17, 2012, reviewed, identifies front belt to be used in interim until an appropriate rear facing belt is received. The consent for the rear facing belt was found, but no consent for use of the front facing belt was found. Staff member # S-102 was asked to show the inspector the consent for the front facing belt, they was unable to do so. The licensee failed to ensure that that restraining of a resident by a physical device may be included in a resident's plan of care only if the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 31. (2) 5.]

Issued on this 7th day of March, 2013

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