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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 8, 2014	2013_211106_0041	S-000063-13	Follow up

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

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 29, 30, 31, 2013

Logs reviewed as part of this inspection: Log# S-000063-13

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care (ADOC), 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:
Minimizing of Restraining

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. The most recent RAI-MDS assessment indicated that resident #020 displayed specific responsive behaviours, 1 to 3 times during the assessment period of 7 days.

Progress notes for resident #020 were reviewed, and indicated that the resident displayed specific responsive behaviours towards a particular co-resident on 28 days from summer 2013 to late fall 2013. The progress notes also indicated that the resident displayed responsive behaviours towards other co-residents, on the 5 different days from summer 2013 to late fall 2013.

On October 31, 2013 during interviews, a PSW told the inspector that resident #020 can display specific responsive behaviours and a RPN told the inspector the resident's behaviours are usually related to a particular resident. The care plan for resident #020 was reviewed, no clear direction was found that directed staff regarding what to do when the resident is displaying a specific responsive behaviour.

The Licensee failed to ensure that there is a written plan of care for each resident that sets out, 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 there is a written plan of care for resident #020, that sets out clear directions to staff and others who provide direct care to the resident, specifically regarding responsive behaviours , to be implemented voluntarily.

WN #2: 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. (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. Resident #023 was observed in their wheelchair with a restraint applied on multiple times during this inspection. Inspector reviewed the home's "Consent For Use of Restraint or Restraint Refusal Form" for resident #023. The form did not have a date and in the space provided for the Substitute Decision Maker (SDM) to sign, "consent over phone" was written and signed by a RN. In the space provided for Witness #1 the same RN had signed the form, the area for witness #2 remained blank. A registered staff member at the nursing desk told the inspector that they did not require the SDM's signature if 2 witnesses signed the form. The inspector reviewed the progress notes with a registered staff member and could not find an entry regarding the call to the SDM to obtain consent to use the restraint. The Licensee failed to ensure that the restraining of a resident by a physical device is 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.]

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 restraining of resident #023 by a physical device is included in the 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, to be implemented voluntarily.

WN #3: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. During all days of this inspection resident #023 was observed in their wheelchair with a restraint applied. The inspector reviewed the "Restraint Record" for resident #023 from October 16 to 31, 2013 and the following was found:

-Oct 16, 2013, from 1600hrs to 2000hrs the restraint was only checked, there was no indication that the restraint was removed and resident repositioned.
-Oct 17, 2013, restraint was applied at 1200hrs and only checked hourly until 1500hrs. From 1600hrs to 2300hrs no documentation was completed to indicate that the resident had been checked or released from the restraint that was applied as of 1500.
-Oct 18, 2013, no restraint documentation was completed from 0800hrs to 1500hrs. At 1600hrs the restraint was checked (not applied), indicating that the restraint had been applied some time before 1600hrs.
-Oct 19, 2013, the restraint was applied at 1100hrs and only checked, but not released until 1700hrs.
-Oct 20, 2013, the applied restraint was released at 1300hrs and only checked until it was next released at 1900hrs.
-Oct 21, 2013, the applied restraint was released at 1400hrs and only checked until resident was in bed at 2100hrs.
-Oct 22, 2013, the restraint was applied at 0900hrs and not released until 1200hrs, it was applied again at 1300hrs and not released until resident went to bed at 2100hrs.
-Oct 23, 2013, the restraint was applied at 1100hrs and not released until 1400hrs, then not released again until 2200hrs.
-Oct 24, 2013, the restraint was applied at 0900hrs and not released until 1200hrs, at 1300hrs the restraint was applied and not released until 2000hrs.
-Oct 25, 2013, the restraint was applied at 0900hrs and not released until 1200hrs, at 1300hrs the restraint was applied and not released until 1600hrs.
-Oct 26, 2013, the restraint was applied at 1100hrs and not released until 1700hrs.
-Oct 27, 2013, the restraint was released at 1300hrs and not released again until 1600hrs, then between 2000hrs and 2300hrs the restraint was only checked and not released.
-Oct 28, 2013, restraint was applied at 1000hrs and not released until 1300hrs, then between 1300hrs and 1600hrs the restraint was only checked and not released.
-Oct 29, 2013, the restraint was applied at 1000hrs and not released until 1300hrs, then between 1300hrs and 2000hrs the restraint was only checked and not released.
-Oct 30, 2013, there was no restraint documentation completed from 0800hrs to 2300hrs, even though resident was observed by inspector to be in wheelchair with the restraint applied.

-Oct 31, 2013, there was no restraint documentation completed from 2400hrs to 1000hrs, even though resident was observed by inspector to be in wheelchair with the restraint applied, on Oct 31, 2013 at 1055hrs.

The Licensee failed to ensure that the resident is released from the physical device and repositioned at least once every two hours. This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself. [s. 110. (2) 4.]

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 resident #023 is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 53. (3)	CO #001	2012_211106_0006	106
O.Reg 79/10 s. 55.	CO #002	2012_211106_0006	106

Issued on this 8th day of January, 2014

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