Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: March 14, 2024
Inspection Number: 2024-1596-0001
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the City of Thunder Bay
Long Term Care Home and City: Pioneer Ridge, Thunder Bay

Lead Inspector	**Inspector Digital Signature**
Lauren Tenhunen (196)	Lauren Tenhunen Digitally signed by Lauren Tenhunen Date: 2024.03.25 09:32:23 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 7 - 9, and 12 - 15, 2024.

The following intakes were inspected:

- One intake for a Critical Incident (CI) related to alleged physical abuse of a resident by staff;
- One intake for a complaint regarding alleged neglect of a resident and reporting; and
- One intake for a CI related to improper/incompetent care of a resident by staff.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

Rational and Summary
A review of the resident's health care records indicated that an area of impaired skin integrity was first identified on the residents' body on a previous date, by staff, when providing care.

The investigation file indicated that staff had not reported this area of impaired skin integrity to the Director of Nursing (DON)/Designate or Administrator when it was first discovered.

An interview with the Director of Care (DOC) confirmed the staff should have reported the area of impaired skin integrity to management at the time it was discovered.

Sources: Review of the home's investigation file, a resident's health care records, including progress notes, care plan; interviews with PSWs, RPNs, RNs, DOC, Administrator, and observations of a picture of the impaired skin integrity. [196]