Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
October 26-29, 2010	2010_106_9599_26Oct101925	Manadatory Report Inspection

Licensee/Titulaire
The Corporation of the City of Thunder Bay, Office of the City Clerk, 500 Donald St. East, Thunder Bay, ON, P7E 5V3
Fax: 807-684-3916

Long-Term Care Home/Foyer de soins de longue durée
Pioneer Ridge, 750 Tungsten Street, Thunder Bay, ON, P7C 6R1
Fax: 807-684-3910

Name of Inspector(s)/Nom de l'inspecteur(s)
Margot Burns-Prouty #106

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Mandatory Report inspection.

During the course of the inspection, the inspector(s) spoke with: Administrator, Assistant Director of Nursing, The Falls Prevention Lead, Registered Practical Nurse and Health Care Aid

During the course of the inspection, the inspector(s): Interviewed staff members, observed care provided to residents in facility, audited electronic plan of care, audited written plan of care, reviewed facility policies and procedures.
The following Inspection Protocols were used in part or in whole during this inspection: Responsive Behaviours

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, C. 8, S. 6(1)(c):
Every licensee of a long-term care home shall 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.

Findings:

1. Interventions listed found in a resident's written plan of care they do not provide clear instructions to direct care staff on how to provide care to the resident. The licensee failed to ensure that the written plan of care for this resident sets out, clear directions to staff and others who provide direct care to the resident.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, S. 53(1)1:
Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Findings:

1. A review of a resident's progress notes, between July 4, 2010 and October 25, 2010, show there were numerous incidents of the resident exhibiting responsive behaviours. This resident's written plan of care does not provide interventions that address these specific behaviours. The licensee failed to ensure that the written approaches to care were developed to meet the needs of a resident in regards to their responsive behaviours.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). January 21, 2011