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

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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 3, 2021	2021_914196_0001	009866-21, 010010-21, 010088-21, 011901-21	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

LAUREN TENHUNEN (196)

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): August 16 - 20, 2021.

The following intakes were inspected upon during this CIS inspection:
- three intakes for resident falls with injury; and
- one intake for an allegation of staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CM), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Services Manager (ESM), Maintenance Workers, Infection Prevention and Control (IPAC) Coordinator, Housekeeping Aides, residents, and a family member.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, observed infection prevention and control practices, reviewed several resident health care records, an internal investigation file, an employee file, air temperature monitoring records and reviewed relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 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. 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 a resident was not neglected by staff.

A Critical Incident System (CIS) report was submitted to the Director, which outlined an allegation of neglect in relation to a resident. The home's investigation determined that a Registered Practical Nurse (RPN) neglected a resident. The resident returned from hospital and they were not provided with the required care on the following shift.

The RPN reported that they only checked on this resident once during the shift. They failed to provide nursing care specific to the resident needs.

The Clinical Manager (CM) reported that the RPN had neglected the resident. They had not completed assessments, and did not provide nursing care specific to the residents needs.

This lack of nursing care, resulted in actual harm to the resident. They were found in pain at the start of the following shift.

Sources: CIS report; homes' investigation file; an RPN's employee records; home's policy titled, "Abuse and Neglect" Revised March 2021; interviews with two RPN's, a CM, Director of Care (DOC), and the Administrator, [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written heat related illness prevention and management plan (HRIPM) for the home that meets the needs of the residents was developed in accordance with evidence-based practices.

On April 1, 2021, the Assistant Deputy Minister (ADM) informed licensees via a memo related to enhanced cooling requirements to the Ontario Regulations (O. Reg) 79/10 of the Long-Term Care Homes Act (LTCHA), 2007. The memo highlighted a summary of the recent amendments to the regulations and that the changes would come into effect on May 15, 2021. In addition, the ADM sent the sector, a memo titled, "Cooling and Air Temperature Requirements for LTCHs A Summary of Changes", in July 2021, which summarized the requirements, including resources that would assist the LTCHs with the development or enhancement to their existing HRIPM plans.

A review of the home's HRIPM plan, titled, "Protocol - Prevention and Management of Heat Related Illness", indicated that the licensee had not revised their plan to reflect the new direction by the Director.

In separate interviews with the DOC and Administrator, they both indicated that they had received the most recent memo from the ADM, and their HRIPM plan was currently in review. The Administrator had indicated that they interpreted that to mean the new regulations were not to be put into place until July 29, 2021. By not revising their HRIPM plan, residents would not be monitored for heat-related illnesses which posed a risk to residents.

Sources: Interviews with the Environmental Services Manager (ESM), DOC and the Administrator; ADM memo dated April 1, 2021, to the sector related to enhanced cooling requirements; home's policy titled, "Protocol - Prevention and Management of Heat Related Illness - date approved: January 1992 (currently under review)" ; the ADM memo dated July 2021 titled, "Cooling and Air Temperature Requirements for LTCHs A Summary of Changes". [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature was measured and documented in writing, in at least one resident common area on every floor of the home, and two resident bedrooms in different parts of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Amendments to Ontario Regulation 79/10 under the LTCHA, 2007, related to enhanced cooling requirements, was sent April 1, 2021, with an effective date of May 15, 2021. These amendments required LTCHs to measure and document the air temperature, at a minimum, in certain specified areas in the LTCH at specified intervals.

The air temperature monitoring records, dated July 1 to August 15, 2021, were reviewed. The air temperature of two resident bedrooms in different areas of the home and at least one common area on every floor was not consistently measured nor documented at the required specified times.

By not measuring and documenting air temperatures of the home, as required, the home would be unable to identify when a temperature related concern occurred. This may have put residents at risk of temperature related illness.

The ESM confirmed that air temperatures were not measured and documented consistently, as required.

Sources: Memo from the ADM, related to enhanced cooling requirements, dated April 1, 2021; the home's "Afternoon, Morning and Evening/Night Temperature Monitoring" records; the home's policy titled, "Protocol - Prevention and Management of Heat Related Illness - date approved: January 1992 (currently under review)"; Interview with the ESM. [s. 21. (2) 1.]

Issued on this 8th day of September, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2021_914196_0001
Log No. / No de registre :	009866-21, 010010-21, 010088-21, 011901-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 3, 2021
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
LTC Home / Foyer de SLD :	Pioneer Ridge 750 Tungsten Street, Thunder Bay, ON, P7A-5C2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lee Mesic

To The Corporation of the City of Thunder Bay, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA, 2007.

Specifically, the licensee must ensure that the identified resident is not neglected by staff.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that a resident was not neglected by staff.

A Critical Incident System (CIS) report was submitted to the Director, which outlined an allegation of neglect in relation to a resident. The home's investigation determined that a Registered Practical Nurse (RPN) neglected a resident. The resident returned from hospital and they were not provided with the required care on the following shift.

The RPN reported that they only checked on this resident once during the shift. They failed to provide nursing care specific to the resident needs.

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This lack of nursing care, resulted in actual harm to the resident. They were found in pain at the start of the following shift.

Sources: CIS report; homes' investigation file; an RPN's employee records; home's policy titled, "Abuse and Neglect" Revised March 2021; interviews with two RPN's, a CM, Director of Care (DOC), and the Administrator, [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was actual harm to a resident.

Scope: The scope of this non-compliance was identified as isolated as it related to one resident.

Compliance history: In the past 36 months, the home had one previous noncompliance under s 19 (1) of the LTCHA.
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 17, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

Service Area Office /
Bureau régional de services : Sudbury Service Area Office