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: December 12, 2023
Inspection Number: 2023-1596-0003
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**
Eva Namysl (000696)	Eva Namysl Digitally signed by Eva Namysl Date: 2023.12.19 15:02:27 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 15-17 and 20-21, 2023.

The following intake(s) were inspected:

- One intake related to Improper care of resident by staff.
- One intake related to a fall of resident resulting in injury.
- One complaint related to concerns re. fall prevention and plan of care.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
Duty to protect
s. 24 (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.

The licensee failed to protect a resident from neglect by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary
A resident had an unwitnessed fall and sustained an injury. The home's internal investigation concluded that, at different times prior to the fall, staff members observed or interacted with the resident and the staff members failed to ensure the resident was safe.

The Director of Nursing (DON) identified that staff should have assisted the resident after observing them in an unsafe position.

There was moderate impact to the resident when the staff observed the resident in an unsafe position but did not assist them, as the resident sustained an injury when they fell.

Sources: Resident's progress notes; Home's internal investigation report; Home's policy: Abuse and Neglect; Interview's with staff and DON. [000696]

WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 4.
PASDs that limit or inhibit movement
Inclusion in plan of care
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
4. The use of the PASD 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.

The licensee failed to ensure the use of the personal assistive safety device (PASD) has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

Rationale and Summary

A resident had a PASD to assist with positioning. Documentation on the resident's progress notes indicated the resident's SDM was consulted regarding the PASD weeks after initial implementation by the staff, and the SDM did not give consent to its use which resulted in it being removed.

There was minimal impact to the resident when the SDM was not involved in making the care decision of implementing a PASD.

Sources: Resident's progress notes and care plan; Observations made during inspection; and Home's Policy: Least restraint policy and Use of PASD'