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
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Original Public Report

Report Issue Date: October 1, 2024

Inspection Number: 2024-1596-0004

Inspection Type:
Complaint
Critical Incident

Licensee: The Corporation of the City of Thunder Bay

Long Term Care Home and City: Pioneer Ridge, Thunder Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9 - 12, 2024

The following intake(s) were inspected:

- Two intakes related to a COVID-19 Outbreak.
- An intake related to alleged neglect of a resident by staff.
- A complaint related to alleged physical abuse of a resident.
- A intake related to alleged physical abuse of a resident by staff

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality.

Rationale and Summary
During a meal service, a staff member, witnessed another staff member interacting with a resident in a manner that did not respect the resident's dignity and autonomy.

In an interview, the Clinical Manger (CM) stated there could have been other ways to approach the resident in the situation.

The home's internal investigation determined the interaction was inappropriate and could be perceived as compromising the resident's personal dignity.

Sources: Submitted CI; Home's internal investigation file; and Interview's with a staff member and a CM.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transfer and positioning techniques when assisting a resident.

Rationale and Summary
While providing support with activities of daily living for a resident, staff members observed the resident to have new altered skin integrity.

The home determined that the altered skin integrity occurred while resident was repositioned.

Sources: Submitted CI; A resident's health records; Long-Term Care Home (LTCH) investigation files; LTCH policies; and interviews with staff, Registered Dietitian, Physician and DON.

WRITTEN NOTIFICATION: Dinning and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that the home had a dining and snack service that included providing a resident with personal assistance and encouragement required to safely eat and drink.

Rationale and Summary
On a particular date, a staff member discovered an untouched meal tray in a resident's room. The resident, as outlined in their care plan, required assistance with eating.

Staff did not provide assistance to the resident with their meal and as a result the resident missed their meal.

Interview with the CM confirmed, residents are entitled to receive at least three meals each day, and that a resident who requires assistance with eating is provided with the appropriate assistance in a timely manner.

Sources: The Home's internal investigation file; Interviews with a CM and staff member; A resident's progress notes; and Summited CI.