



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

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**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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 13, 2014	2013_211106_0040	S-000421-13	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF THUNDER BAY
c/o Dawson Court, 523 Algoma Street North, THUNDER BAY, ON, P7A-5C2

Long-Term Care Home/Foyer de soins de longue durée

PIONEER RIDGE
750 TUNGSTEN STREET, THUNDER BAY, ON, P7B-6R1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 29, 30, 31, 2013

Logs reviewed as part of this inspection: Log # S-000421-13

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. A critical incident report, submitted to the Ministry of Health and Long-Term Care, indicated that, the family of resident #001 brought forward concerns that the resident had to wait an extended period of time for staff to respond to their call bell. On October 29, 2013 the ADOC provided inspectors with the home's investigation into the above complaint. The home's investigation was reviewed and it indicated that, resident #001 waited for approximately 108 minutes to receive care from staff.

Oct 29, 2013, a family member to resident #001, told the inspector that they had on going concerns regarding the resident having to wait for long periods of time to receive care. On October 30, 2013, during an interview, resident #001 told the inspector that in the past they has had to wait a long time for staff to assist them with care.

The Licensee failed to ensure that resident #001's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs was fully respected and promoted. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. A critical incident report, submitted to the Ministry of Health and Long-Term Care, indicated that, the family of resident #001 brought forward concerns that the resident had to wait an extended period of time for staff to respond to their call bell. On October 29, 2013 the ADOC provided inspectors with the home's investigation into the above complaint. The home's investigation was reviewed and it indicated that, resident #001 waited for approximately 108 minutes to receive care from staff.

The care plan for resident #001 was reviewed by inspector, which indicated, staff are to assist resident with care during a specific time frame. The Licensee failed to ensure that the care set out in the plan of care for resident #001 was provided as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for resident #001 is provided as specified in the plan, specifically in regards to personal care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

- 1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
- 2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
- 3. Behaviour management. 2007, c. 8, s. 76. (7).**
- 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
- 5. Palliative care. 2007, c. 8, s. 76. (7).**
- 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

Findings/Faits saillants :

1. On October 30, 2013, the Education Coordinator, provided inspector with a typed synopsis of number of nursing staff members who did not complete abuse training in the last 12 months. The members of the nursing staff who did not complete abuse training in the last 12 months are as follows:

- Full time nursing staff members: 1/42
- Part time nursing staff members: 22/95
- Casual nursing staff members: 13/26

The licensee failed to ensure that all staff members who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention. [s. 76. (7) 1.]



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Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff members who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention., to be implemented voluntarily.

Issued on this 14th day of January, 2014

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

A handwritten signature in black ink, appearing to be "M. [unclear]".