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

Public Report

Report Issue Date: June 19, 2025

Inspection Number: 2025-1596-0002

Inspection Type:
Critical Incident
Follow up

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): June 9 -13, 2025

The following intake(s) were inspected:

- One intake for a follow-up to compliance order #002 issued for O. Reg. 246/22 s. 102 (2) (b) related to the IPAC Program;
- One intake for a follow-up to compliance order #001 issued for O. Reg. 246/22 s. 40 related to transferring and positioning techniques;
- One intake related to improper/incompetent care of resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1596-0001 related to O. Reg. 246/22, s. 102 (2) (b)
Order #001 from Inspection #2025-1596-0001 related to O. Reg. 246/22, s. 40

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

Staff did not collaborate effectively, resulting in miscommunication about a resident's preferences and care not being provided in accordance with the care plan.

Sources: A critical incident report; a resident's health records; Long-term Care

Home (LTCH) investigation file; interviews with staff, Director of Nursing (DON) and the Administrator.

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