Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 10, 2016	2016_282543_0011	026993-15	Complaint

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street PO Box 5000 Stn A SUDBURY ON P3A 5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE SUDBURY ON P3A 2T4

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

TIFFANY BOUCHER (543), SARAH CHARETTE (612)

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): April 4-8 and 11th, 2016

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and annual program evaluation records.

This Complaint inspection is related to (Log #026993-15, #028842-15, #034048-15, #000093-16, #001315-16) care concerns, (Log #027300-15, #027584-15, #033238-15) staffing concerns, (Log #036075-15) medication, (Log #000836-16) falls, (Log #002094-16, #005389-16) environmental concerns.

A Critical Incident Inspection #2016_320612_0009, and a follow-up inspection #2016_320612_0010 was conducted concurrently related to (Log #004663-16) immediate investigation of alleged, suspected or witnessed incidents of abuse (compliance order (CO) #001), and the annual evaluation of the home's abuse program (CO#002); (Log #000979-16) the duty to protect residents from abuse and neglect (CO #001), the home's abuse policy (CO#002) and insufficient staffing (CO #005); (Log #000982-16) immediate reporting (#003), complying with the home's skin and wound, responsive behaviour and medication policies (#004), managing responsive behaviours (#006), and the residents' plan of care (CO#008 and #009).

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MRC), Program Coordinators (PCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Manager of Physical Services, Laundry Housekeeping and Material Control Services Manager, Scheduling Coordinator, Manager of Administration, Housekeepers, and residents and their family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 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	Legendé 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. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's right to have their personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential.

Concerns were brought forward by resident #001's family related to the licensee sharing this resident's personal information with individuals who were not the resident's substitute decision maker.

The inspector reviewed this resident's health care record. Progress notes identified that Physician #119 provided information to individuals who were not the resident's SDM. The progress notes indicated that this resident's health care record would be updated to reflect that no personal information was to be shared with anyone other than their SDM.

In an interview with PC #103, they confirmed that in the past information was provided to individuals who were not resident #001's SDM. [s. 3. (1) 11. iv.]

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Issued on this 26th day of May, 2016

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

Original report signed by the inspector.