Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Melissa Chisholm	**Inspector ID #**	001
Log #:	S-00905		
Inspection Report #:	2011_188_9566_01Feb160847		
Type of Inspection:	Complaint		
Date of Inspection:	February 2nd, 3rd, 2011		
Licensee:	The City of Greater Sudbury, 200 Brady Street, PO Box 5000 Station A, Sudbury, ON, P3A 5P3. F 705-566-6926		
LTC Home:	Pioneer Manor 960 Notre Dame Ave, Sudbury, ON P3A 2T4, F 705-566-6926		
Name of Administrator:	Tony Parmar		

To the City of Greater Sudbury, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: O. Reg. 79/10, s.24(2)1 The care plan must identify the resident and must include, at a minimum, the following with respect to the resident. 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.			
Order: The licensee shall ensure that any identified risks a newly admitted resident poses to themselves are documented in the care plan and interventions to mitigate those risks are identified.			
Grounds: 1. Inspector reviewed the health care record for a resident. It was identified through an assessment that this resident posed a safety risk related to equipment use. This safety risk was not documented in the resident's care plan. Interventions to mitigate the identified safety risk where not developed or implement. The resident suffered a fracture following an incident involving the equipment. The licensee failed to include in the resident's care plan the identified safety risk and interventions to mitigate this risk.			
This order must be complied with by:	Immediately		

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 18 day of March , 2011.	
Signature of Inspector:	
Name of Inspector:	Melissa Chisholm
Service Area Office:	Sudbury

Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
Sudbury ON P3E 6A5

Telephone: 705-564-3130
Facsimile: 705-564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
Sudbury ON P3E 6A5

Téléphone: 705-564-3130
Télécopieur: 705-564-3133

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
February 2nd, 3rd, 2011	2011_188_9566_01Feb160847	Complaint Log # S-00905, IL-16435-SU

Licensee/Titulaire
The City of Greater Sudbury, 200 Brady Street, PO Box 5000 Station A, Sudbury, ON, P3A 5P3. F 705-566-6926

Long-Term Care Home/Foyer de soins de longue durée
Pioneer Manor 960 Notre Dame Ave, Sudbury, ON P3A 2T4, F 705-566-6926

Name of Inspector/Nom de l'inspecteur
Melissa Chisholm 188

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the Manager of Resident Care, Manger of Therapeutic Services, Program Coordinators, Registered Nursing staff, Personal Support Workers, Physiotherapist, Occupational Therapist (OT), and the resident named in the complaint.

During the course of the inspection, the inspector: Conducted a walk-through of all resident home areas and various common areas, observed the resident named in the complaint, observed staff practices and interactions with the resident, and reviewed the following:

- Policies and procedures related to incident reporting
- Health care records of resident named in the complaint
- Resident equipment storage and availability

The following Inspection Protocols were used during this inspection:
Personal Support Services
Critical Incident Reporting

Findings of Non-Compliance were found during this inspection. The following action was taken:

7 WN
1 CO: CO #001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

1. Inspector reviewed the plan of care for a resident. The plan of care indicated the resident eats all meals in the dinning room. The inspector observed the resident eating breakfast in their room. The licensee failed to ensure care set out in the plan of care was provided to the resident as specified in the plan.

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WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.24(2)1 The care plan must identify the resident and must include, at a minimum, the following with respect to the resident. 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Findings:

1. Inspector reviewed the health care record for a resident. It was identified through an assessment that this resident posed a safety risk related to equipment use. This safety risk was not documented in the resident's care plan. Interventions to mitigate the identified safety risk where not developed or implement. The resident suffered a fracture following an incident involving the equipment. The licensee failed to include in the resident's care plan the identified safety risk and interventions to mitigate this risk.

Inspector ID #:	188

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s.107(3)4 The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

Findings:

1. An incident occurred on January 25, 2011. The resident sustained an injury and was transferred to hospital. This incident was first reported to the ministry via the Critical Incident System on January 27,

2011. This is not in accordance with the required time frame of one business day after the occurrence.

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WN #4: The Licensee has failed to comply with O. Reg. 79/10, s.107(4)3 A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident, including, i) what care was given or action taken as a result of the incident, and by whom, ii) whether a physician or registered nurse in the extended class was contacted, iii) what other authorities were contacted about the incident, in any, iv) for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v) the out outcome or current status of the individual or individuals who were involved in the incident.

Findings:

1. The inspector reviewed a critical incident report. Both the original and amended report does not identify the name of the substitute decision-maker of the resident that was contacted following the incident. The licensee failed to identify the name of the substitute decision maker contacted in the written report to the Director.

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WN #5: The Licensee has failed to comply with O. Reg. 79/10, s.17(1)b Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, is on at all times

Findings:

1. Inspector entered a room to speak with a resident on February 2, 2011. The resident identified to the inspector that they had pressed the call bell and where waiting for assistance. Inspector observed the resident press the wireless call badge a second time. The light outside the room did not activate. The inspector proceeded to press the wireless call badge. The communication-response system still did not activate. Inspector went to nursing station and returned to the resident's room with the registered practical nurse (RPN). The RPN pushed the wireless call badge and it did not activate. The RPN told the inspector and the resident that the battery must be dead in the wireless call badge. The RPN proceeded to obtain and change the battery in the wireless call badge. The wireless call badge did activate after the battery was changed and it was pushed by the RPN. The licensee has failed to ensure the resident-staff communication and response system is on at all times.

Inspector ID #:	188

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s.30(1)2 Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

Findings:

1. Inspector reviewed the health care record for a resident. It was identified during an assessment that the resident was unsafe to use equipment independently. The resident continued to use the same

equipment the following day and an incident occurred resulting in an injury to the resident. The licensee failed to ensure that the equipment used for a resident was appropriate for them based on their condition.	
Inspector ID #:	188

WN #7: The Licensee has failed to comply with O. Reg 79/10, s.8(1)b Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is in compliance with and is implemented in accordance with all applicable requirements under the Act; is complied with.

Findings:

1. The inspector reviewed policy titled INCIDENT: REPORT OF obtained from Pioneer Manors electronic policy library February 3, 2011. The policy indicates the following under the procedure section:
   - 1. a) Record pertinent information on the following forms where applicable: (1) Progress Notes (2) Incident Report form: check all appropriate squares, cross off sections that do not apply, complete both sides and sign report, copy reports concerning visitor incidents to the Administrator.

   The incident involving a resident occurred as indicated in the progress notes. No incident report had been generated for the incident. The Program Coordinator confirmed to the inspector that an incident report was not created following the incident as per the policy. The licensee failed to ensure their policy title INCIDENT: REPORT OF was complied with.

Inspector ID #:	188

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). March 18, 2011