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 soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2017	2017_657681_0014	016744-17, 020365-17, 023878-17	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

STEPHANIE DONI (681), TIFFANY BOUCHER (543)

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): November 14-17, 2017, and November 20-24, 2017.

Three intakes related to resident care concerns were inspected on during this Complaint inspection.

A Critical Incident System (CIS) inspection #2017_657681_0013 and a Follow Up inspection #2017_657681_0015 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Coordinator of Education and Special Services, Program Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

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

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A complaint was submitted to the Director related to care concerns for resident #011. The complainant alleged that a specified device was not always applied.

Inspector #543 reviewed resident #011's most recent care plan, which indicated that staff would ensure that a specified device was in place at all times when the resident was in bed.

On a particular day, Inspector #543 observed resident #011 sleeping in bed. The Inspector noted that the specified device was not applied. Inspector #543 interviewed PSW #131 who also observed resident #011 and verified that the resident did not have the specified device in place at the time of the observation.

The Inspector reviewed the progress notes in resident #011's electronic medical record. A progress note indicated that the specified device had been removed and that resident #011's substitute decision maker (SDM) had verbally consented to this change.

During an interview with Inspector #543, RPN #132 stated that there was a progress note which indicated that the specified device had been removed. RPN #132 acknowledged that resident #011's care plan identified the need for the specified device and verified that the resident's plan of care was not up to date. [s. 6. (10) (b)]

2. A complaint was submitted to the Director related to allegations of improper care of resident #013.

Inspector #543 reviewed resident #013's most recent care plan, which indicated that resident #013 only received a specified type of bath because of altered skin integrity. The care plan identified that resident #013 was supposed to receive a specified type of bath on two specific days of the week.

Inspector #543 interviewed PSW #122, who regularly cared for resident #013. PSW #122 indicated that resident #013 now received another type of bath on two specific days of the week.

Inspector #543 interviewed RPN #121 who verified that resident #013 no longer required the specified type of bath and that they received another type of bath on two specific days of the week. The RPN verified that resident #013's care plan had not been updated since their care needs had changed. [s. 6. (10) (b)]

Issued on this 2nd day of January, 2018

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

Original report signed by the inspector.