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

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

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 11-13/2011	2011_158_9566_11Apr11232 5	Complaint S-01014

Licensee/Titulaire
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

Name of Inspector(s)/Nom de l'inspecteur(s)
Kelly-Jean Schienbein (158)

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:
Administrator, Director of Care, Medical Director, Nursing Program Coordinators, registered nursing staff, personal support workers (PSW), food service worker (FSW), housekeeping staff, maintenance staff and visitors.

During the course of the inspection, the inspector: Conducted a walk throughout of all resident areas and various common areas, observed the care of residents, observed meal service, observed medication administration and interviewed residents, staff and a family member.
The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Environment

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

9 WN
3 VPC

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 (1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. The inspector reviewed a resident's plan of care for toileting on April 11/11. The care plan only stated that two staff are to use the sit to stand lift for the transfer onto the toilet. This resident's need for assistance with perineal cleansing and clothes adjustment as assessed in RAI/MDS was not identified in the care plan.
2. This resident's assessed need for incontinence management in RAI/MDS was identified as a

toileting schedule, however, there was no toileting schedule identified in the plan of care to manage the resident's urinary incontinence.
3. The plan of care for this resident did not provide clear direction to staff or others who provide direct care.

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WN # 2: The Licensee has failed to comply with LTCHA, 2007,S.O. 2007, c.8, s.6 (10)(b)
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, the resident's care needs change or care set out in the plan is no longer necessary;

Findings:
1. The Physiotherapist reassessed a resident and identified that the transferring assistance for this resident is a one person assist with a transfer belt. The resident's plan of care which was reviewed by the inspector on April 11/11 stated however that the resident's transfer assistance is: two staff to use the sit to stand lift
2. The resident's plan of care was not revised when the resident's assessed care needs changed.

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WN # 3: The Licensee has failed to comply with LTCHA, 2007,S.O. 2007, c.8, s. 6(5)
The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Findings:
1. A resident's health care record was reviewed by the inspector on April 12/11. This resident was placed on "isolation" as a precaution during an outbreak. The resident's family was not notified of the implementation of the isolation procedure for this resident.
2. The health record of a resident who had two separate falls was reviewed by the inspector on April 12/11. The resident's two "fall incident reports" and the resident's progress notes were reviewed by the inspector on April 12/11 and show that the home did not notify the family member of the falls.
3. The substitute decision maker was not given an opportunity to participate in the development or implementation of the resident's plan of care.

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WN # 4: 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. The inspector observed that a resident was transferred on April 11/11 at 1130h into a wheel chair by one PSW without using the transfer belt as specified in the resident's plan of care.
2. This resident was also observed to be transferred by one staff onto the toilet. The resident's plan of care identified that two staff are to use the sit to stand lift when transferring the resident onto the toilet.
3. The resident did not have access to a manual call bell during the planned power outage on April 11/11 at 1330h to 1530h. The resident's plan of care identified that the call bell is to be placed within the resident's reach at all times.
4. Care was not provided to resident as specified in the plan of care.

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WN # 5: The Licensee has failed to comply with O.Reg. 79/10, 2007, s. 17(1)(d)
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 available at each bed, toilet, bath and shower location used by residents;

Findings:

1. A scheduled power interruption occurred on April 11/11 at 1300h until 1530h. The home's contingency plan for this power interruption identified that "silver call bells will be provided to each unit to replace Versus".
2. The inspector observed that there were no manual "silver call bells" made available to the residents on one unit or at their bedsides during this power interruption.
3. The home did not ensure that that resident-staff communication system was available at each resident's bedside.

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WN # 6: The Licensee has failed to comply with O. Reg. 79/10, 2007, s. 229(4)
The licensee shall ensure that all staff participate in the implementation of the program.

Findings:

1. The inspector reviewed the home's isolation policy regarding contact precautions. The policy reads that an isolation gown is to be worn by staff "for all activities in the room". The inspector observed a PSW on one unit enter a room where the resident was in isolation with Contact Precautions on April 11/11 at 1115h. The PSW entered the room without wearing an isolation gown.
2. The RPN administering medication on one unit on April 13/11 was observed by the inspector to use her hands to assist a resident to open their mouth. The RPN's hands were not washed before or after assisting the resident.
3. The inspector continued to observe this RPN administering medication to other residents on the unit. The RPN's hands were not washed between the residents the RPN was administering medications to.
4. The staff did not participate in the implementation of the infection control program.

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WN # 7: The Licensee has failed to comply with O. Reg. 79/10, 2007, s. 51(2)(b)
Every licensee of a long-term care home shall ensure that, each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

Findings:

1. A resident's health care record was reviewed on April 12/11 by the inspector. The plan of care identified that this resident is incontinent. This resident's assessed need for incontinence management in RAI/MDS is identified as a toileting schedule, however, there was no toileting schedule identified in the plan of care to manage the resident's urinary incontinence.

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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 ensuring that all residents who are incontinent have an individual plan of care to promote and manage urinary incontinence, to be implemented

voluntarily.

WN # 8: The Licensee has failed to comply with O. Reg. 79/10, 2007, s. 49(2)
Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Findings:

1. The health record of a resident who had two separate falls was reviewed by the inspector on April 12/11.
2. The resident's head injury record (HIR) observation sheet was reviewed by the inspector for two falls. The home's head injury policy states monitor "vital signs (BP, pulse, respirations) immediately following the incident, then again in 1 hour, then once each shift X 3 shifts. Documentation of vital signs taken one hour post fall and on the evening shift for fall # 1 was not found. Documentation of vital signs taken one hour post fall and on the night shift for fall # 2 was not found.
3. A complete post fall assessment was not conducted as per the home's head injury routine.

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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, ensuring that the post-fall assessment is conducted when a resident falls, to be implemented voluntarily.

WN # 9: The Licensee has failed to comply with O. Reg. 79/10, 2007, s. 90(2)(i)
The licensee shall ensure that procedures are developed and implemented to ensure that, the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

Findings:

1. The water temperatures taken in the spa located in the double room area of one unit at 10:50h on April 13/11 read 32.9 Celsius at the bath tub, and in 33.3 Celsius at the shower. The water temperature was also taken at a resident's bathroom sink and it read 37.3 Celsius.

2. The RPN and PSW on another unit confirmed during the April 13/11 interview with the inspector that two residents did not receive their baths as the water serving the bathtub and shower was cold to touch at 1030h.

3. The licensee did not ensure that the temperature of the hot water serving the bathtubs and showers used by residents on two units was maintained at 40 degrees Celsius on April 13/11 as indicated by:

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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 ensuring that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, to be implemented voluntarily.

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.** Aug 3/11
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).