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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2019	2019_768693_0001	033138-18	Complaint

Licensee/Titulaire de permis

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

MELISSA HAMILTON (693)

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): January 8-11, 2019.

The following was inspected upon:
One complaint submitted to the Director related to alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Program Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the 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 complemented each other.

A complaint was received by the Director on an identified date, regarding allegations of staff to resident neglect towards resident #001, which resulted in a medical diagnosis causing two other medical diagnoses, resulting in the death of resident #001.

A review of resident #001's progress notes from a two month time period in an identified year, revealed that on seven specific dates a note was made by a registered staff member relating to a medical abnormality in resident #001.

The progress note for resident #001 from an identified date, composed by RN #103, indicated that on this day resident #001 was assessed by RN #103 for a the identified medical abnormality. RN #103 indicated in this note that this medical abnormality had been an issue for resident #001 since a specified month in an identified year, and at that time treatments were ordered. RN #103 identified that they would place a note about this in the doctor's book.

In an interview with RN #103, they stated that RNs and RPNs communicate non-urgent areas of concern for residents to the physicians by placing a note in the physician's book for the physician to assess when they are in next. RN#103 and Inspector #693 reviewed the progress note entry composed by RN #103, and they stated they did not remember whether or not they wrote this in the doctor's book as they had indicated they had done and could not remember if this issue was followed up on for resident #001 by the

physician.

Inspector #693 reviewed the doctor's book as well as the physician orders for resident #001 for a 10 month time period in a specified year, and did not identify any orders or notes relating to the identified medical abnormality.

Together with the Inspector, the Manager of Resident Care reviewed the doctor's book notes for resident #001 for a 10 month time period in a specified year, and confirmed that there were no notes in the book by the registered staff members that identified the specified medical abnormality and that there was no evidence that the registered staff members had collaborated with the physician about resident #001's care relating to this concern. [s. 6. (4) (b)]

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 to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

An identified section of the Ontario Regulation 79/10, requires the licensee to ensure that a specific program included treatments and interventions to prevent a medical condition.

A complaint was received by the Director on an identified date, regarding allegations of staff to resident neglect towards resident #001, which resulted in a medical diagnosis causing two other medical diagnoses, resulting in the death of resident #001.

A review of resident #001's identified function monitoring record for a one month period in a specific year, identified that for a four day period in the specific year, resident #001 did not have a normal bodily function occur.

In an interview with PSW #100, they stated that it was the responsibility of the PSW on each shift to document the occurrence of the identified normal bodily function for each resident they were providing care for on the Point of Care (POC) system. They stated that if the resident had not had an occurrence of the identified normal bodily function in two or more days the POC dashboard would alert, and the PSW was responsible for reporting this to the RPN so that they could implement the home's management program.

In an interview with RPN #102, they stated that the home had an identified normal bodily function management policy and protocol relating to the specific medical condition, in which a resident who had not had an occurrence of the identified normal bodily function in two days, was administered an increase in a specified treatment classification. RPN #102 went on to state that a resident who had not had an occurrence of the identified normal bodily function in three days was given a specific treatment on this day and each consecutive day without the occurrence of the identified normal bodily function, and if the specific treatment was ineffective the resident was given a different treatment on the third or fourth day without the occurrence of the identified normal bodily function, unless this was the resident's normal pattern. RPN #102 stated that the registered staff who had worked the night shift would have reviewed the documentation for each resident and charted in the progress notes if interventions needed to be implemented on the day shift to prevent the identified medical condition.

Inspector #693 obtained a copy of the home's policy, with a specified title, issued on an identified date in a specified year, from the Manager of Resident Care. The policy outlined that the identified management protocol was for the afternoon registered staff member to have administered a specific treatment as per the physician's order or medical directive in the evening when there was an absence of an occurrence of the identified normal bodily function for two days and each consecutive day the resident had not had an occurrence of the identified normal bodily function, unless it was the resident's normal established pattern. The night shift registered staff member would have administered a treatment on the third and each consecutive day the resident had not had an occurrence of the identified normal bodily function as per physician's order or medical directive. If the second administered treatment was ineffective, another treatment was to be administered on the third or fourth day without the occurrence of the identified normal bodily function as per physician's order or medical directive

A review of the progress notes for resident #001 for a one month period in a specified year, identified that the night shift RPN on a specific date, identified that resident #001 had not had an occurrence of the identified normal bodily function in three days and was to be given an increase in a specific treatment and that the night shift RPN on another specific date, identified that resident #001 had not had an occurrence of the identified normal bodily function in four days.

Together with the Inspector, Program Coordinator #101 reviewed resident #001's Electronic Medication Administration Record (EMAR) for a one month period in a specified year, and confirmed that resident #001 did not receive any treatments to manage the absence of occurrence of the identified normal bodily function during this period and that as per the home's policy they should have. [s. 8. (1) (b)]

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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.