Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Apr 3, 2019	2019_657681_0004	033269-18, 001195-19	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

STEPHANIE DONI (681), CHAD CAMPS (609)

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): February 13 - 15, 2019.

The following intakes were inspected on during this Complaint inspection:
- Two intakes related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Director, Manager of Resident Care (MORC), Manager of Therapeutic Services, Manager of Food Services, Program Coordinators, Pharmacist, Occupational Therapist (OT), Registered Dietitian (RD), Physician Liaison, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), Nutritional Aides (NAs), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, and relevant 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:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (5).

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. 2007, c. 8, s. 6 (7).

s. 6. (12) 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 explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident set out the planned care for the resident.

A complaint was submitted to the Director related to concerns about resident #002's safety.

a) On a specified date, Inspector #609 observed a specified intervention in place for resident #002.

During an interview with PSW #104, they stated that resident #002 had the specified intervention in place for a specific reason.

A review of resident #002's plan of care found no indication that the specified intervention was to be implemented.

b) Inspector #609 also observed the specified intervention in place for resident #004 and resident #005.

During an interview with PSW #104, they stated that resident #004 and resident #005 had the specified intervention in place.

A review of the home’s policy titled “Documentation Resident Care Plan” last revised September 2, 2018, indicated that all residents would have an individualized care plan that reflected their needs which included preferences, safety and security risks.

A review of the plan of care for residents #004 and #005 found no indication that the specified intervention was to be implemented.

During an interview with RN #108, they verified that residents #002, #004 and #005 had the specified intervention in place. A review of the plan of care for all three residents was conducted with the RN, who verified that the specified intervention was not set out in the residents’ plan of care and that it should have been included in their care plan.

During an interview with Program Coordinator #106, they indicated that it was the expectation of the home that care provided to the resident was set out in the resident’s plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

A complaint was submitted to the Director, which outlined concerns related to responsive behaviours, the home’s communication and response system, short staffing and the administration of medications and food services.

a) Inspector #609 reviewed resident #002’s health care record and identified a progress note, which indicated that RN #108 informed the resident’s family member that staff had difficulty administering the resident's specified medication at the prescribed time intervals and that staff would continue to "try" and ensure Physician #121's orders were followed.

A review of resident #002’s health care record found an order from Physician #121 for a

specified medication that was to be administered at specific time intervals.

During an interview with RN #108, they outlined how they faxed a request to Physician #121 to have the prescription changed for the specified medication because the frequency was too time consuming for staff to perform.

RN #108 denied involving resident #002 or their family in the decision to send a fax requesting a change to the resident's prescription.

The Inspector reviewed the home's policy titled "Documentation Resident Care Plan" last revised September 2, 2018, which indicated that the resident care plan was to reflect the needs and care wishes of the resident and was to incorporate input from the resident and/or family.

During an interview with the MORC, they indicated that resident #002 and/or their family should have been involved before RN #108 decided to send a fax to Physician #121 requesting a change to the resident's prescription.

b) Inspector #609 reviewed resident #002's health care record and identified a progress note which indicated that, after the resident's family member was informed by RN #108 about the difficulty administering resident #002's specified medication, the family member was "firm" that Program Coordinator #106 had told the family that the resident's prescription was "doable" by the staff of the home.

During an interview with RN #108, they denied being aware that Program Coordinator #106 had previously provided assurance to resident #002's family member that staff could manage the resident's specified prescription.

A further review of resident #002's health care record found no mention of any conversation between Program Coordinator #106 and the resident or the resident's family members about the resident's prescription.

During an interview with Program Coordinator #106, they verified that they had spoken with resident #002's family member and had assured them that staff would be able to administer the resident's medication. The Program Coordinator also verified that they did not document the conversation that they had with resident #002's family member.

The Inspector spoke with Program Coordinator #106 about the home's plan to address

the resident’s likely need for the specified medication. Program Coordinator #106 provided the Inspector with a consult plan that was going to be sent to Physician #121. The consult plan included three specified options. Program Coordinator #106 stated that once Physician #121 selected one of the three options, they would inform the resident.

During the same interview, Program Coordinator #106 was asked if the resident or the family were aware of, or consented to, the three options decided by the home, or consented to send the consult plan to Physician #121. Program Coordinator #106 denied any involvement or awareness of resident #002 or their family in the three options that were to be faxed to Physician #121.

During an interview with the MORC, a review of the three options to have been faxed to Physician #121 was conducted. The MORC verified that the resident and family should have been involved before a letter was made requesting a change to the resident’s prescription.

c) During an interview with the complainant, they advised Inspector #609 that resident #002 required a specified medication. The complainant stated that they were told by RPN #119 that the RPN did not have enough time to administer the scheduled medication.

The Inspector reviewed resident #002’s health care record, which included an order written by Physician #121 for a specified medication to be administered at specific time intervals. A notation under the order indicated that the patient or family could administer the medication.

A review of resident #002’s health care record found a progress note, which indicated that the resident was unable to self-administer the medication and that the RPN assisted “when possible”.

During an interview with RPN #119, they indicated that the Medical Director had stated that resident #002 or their family could administer the prescribed medication.

However, RPN #119 verified that the resident was unable to self-administer the medication and that the resident’s family had already left and were unavailable to assist with the medication.

RPN #119 indicated that, as a result, some of the doses of the medication were administered late. [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Director related to falls that resident #001 had experienced.

Inspector #681 reviewed resident #001's electronic care plan, which identified that a specified falls prevention intervention was to be implemented for the resident. The Inspector identified that this intervention was initiated by Program Coordinator #115 on a specified date.

The Inspector reviewed resident #001's health care record and identified a progress note that was entered by RPN #110 on a later date. The progress note indicated that resident #001 sustained a fall and that the specified falls prevention intervention was not in place at the time of the fall.

During an interview with resident #001's substitute decision maker (SDM), they indicated to the Inspector that resident #001 was to have a specified falls prevention intervention in place.

During an interview with RPN #110, they stated that they were working when resident #001 sustained a fall. RPN #110 stated that the specified falls prevention intervention was not in place when the resident fell. RPN #110 stated that staff did not follow resident #001's plan of care because the intervention should have been implemented.

During an interview with Program Coordinator #115, they stated that the specified falls prevention intervention should have been implemented at the time of resident #001's fall. Program Coordinator #115 acknowledged that care was not provided to resident #001 as per the resident's plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an explanation of the plan of care.

A complaint was submitted to the Director, which outlined concerns related to responsive behaviours, the home's communication and response system, short staffing and the administration of medications and food services.

During an interview with resident #002, they indicated to Inspector #609 that a specified device had been applied to their bed by their family. The resident also stated that approximately one week ago an unknown staff member had assessed their bed and told them that the specified device had to be removed.

A review of resident #002’s health care record found no documentation to support any assessment or conversation with the resident about the specified device on their bed.

The Inspector reviewed the home’s policy titled “Documentation Practices” last revised June 17, 2016, which outlined how documentation was to reflect the care that the resident received.

During an interview with Program Coordinator #106, they verified that they had received a call from resident #002’s family member, asking them why the specified device had to be removed from the resident's bed. The Program Coordinator further verified that, as of one week after receiving the call from resident #002's family, the Program Coordinator still did not know who had spoken with the resident or why the specified device had to be removed.

During an interview with the Manager of Therapeutic Services, they verified that they had assessed resident #002’s bed and identified that a specified device had been applied to the bed. The Manager of Therapeutic Services stated that they advised resident #002 that the specified device was of a particular risk and that the device had to be removed.

The Manager of Therapeutic Services acknowledged that they did not document their assessment or the conversation that they had with resident #002 about the specified device on the resident's bed.

During an interview with the MORC, they acknowledged that if the Manager of Therapeutic Services documented their assessment and conversation with resident #002, then Program Coordinator #106 would have been able to address the family's concerns about the removal of the specified device. [s. 6. (12)]

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 there is a written plan of care for each resident that sets out the planned care for the resident; 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; and that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

A complaint was submitted to the Director related to resident #001's texture modified diet.

During a meal observation in a specified dining room, Inspector #681 observed Nutritional Aide #114 remove a dirty plate from in front of a resident and then serve the next course to residents without performing hand hygiene. The Inspector observed that the Nutritional Aide removed two additional dirty dishes from in front of residents and then continued to serve dessert to other residents without again performing hand hygiene. The Inspector also observed that Nutritional Aide #114 touched their face on two separate instances during the meal service and that hand hygiene was not performed between touching their face and serving food items to residents.

The Inspector reviewed the home’s policy titled "Infection Prevention and Control Program: Hand Hygiene Program" last revised May 31, 2016, which indicated that the Four Moments for Hand Hygiene in Health Care were before initial resident or environment contact, before aseptic procedure, after body fluid exposure risk, and after resident or environment contact. The policy also indicated that hands were to be cleaned before assisting with meals or snacks and, if during assisting with meals or snacks, there was exposure of the hands to saliva or mucous membranes, hands should be cleaned before continuing.

The Inspector also reviewed a document titled “Nutritional Services Orientation – Pleasurable Resident Dining”, which was provided to the Inspector by the Manager of Food Services. The document indicated that staff were to wash their hands after removing dirty dishes and before serving the next course.

During an interview with Nutritional Aide #114, they stated that there was a requirement to wash their hands between clearing dirty dishes and serving the next meal course. Nutritional Aide #114 also stated that they were to wash their hands after touching their face during a meal service. The Inspector reviewed their observations with Nutritional Aide #114 and the Nutritional Aide acknowledged that they did not wash their hands between removing dirty dishes from certain residents and serving dessert to other residents.

During an interview with the Manager of Food Services, they stated that the expectation was that staff wash their hands before going into the dining room and then again when they move from handling dirty dishes to serving the next course. The Manager of Food Services also stated that staff were to wash their hands anytime their hands became soiled during the meal service. [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

Issued on this 3rd day of April, 2019

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

Original report signed by the inspector.