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
Sep 12, 2019	2019_794749_0020	010966-19, 011105-19, 012289-19, 015396-19, 016757-19	Critical Incident System

Licensee/Titulaire de permis

City of Greater Sudbury
200 Brady Street 4th Floor SUDBURY ON P3E 3L9

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

AMY PAGE (749), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 26 to 30, 2019.

The following intakes were inspected during this Critical Incident Inspection:
- Three intakes related to falls which resulted in an injury;
- One intake related to resident to resident physical abuse; and
- One intake related to resident elopement.

A Complaint Inspection #2019_794749_0021 was conducted concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with the Director, Acting Manager of Resident Care (AMORC), Program Coordinators (PCs), Resident Care Coordinator (RCC), Occupational Therapist (OT), Physical Therapist (PT), Manager of Therapeutic Services (MOTS), Scheduling Clerk, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), family members and residents.

Inspector(s) also conducted daily tours of the resident care areas, observed provision of care and services, reviewed relevant licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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. (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 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 critical incident (CI) report was submitted to the Director on a specific date, regarding resident #008 leaving the home without notifying a staff member.

A review of resident #008's medical record indicated that the resident's elopement risk was last assessed three months prior to the incident and was identified at a specific risk level.

In a review of the home's policy titled "Documentation Resident Care Plan" last revised September 2, 2018, it indicated that "A resident's plan of care would be re-assessed during resident admission/annual care conferences, when current status has changed and quarterly."

In an interview with PSW #121, they stated that on a specific date, resident #008 informed the PSW that they wanted to leave the home and that the PSW had reported this to RPN #118. The PSW further stated that resident #008 recently had a change in their health status.

During an interview with RPN #122, they stated that resident #008 previously had an elopement risk assessment completed, but the resident recently had a change in their health status.

In an interview with the Acting Resident Care Manager (ARCM), they acknowledged that on a specified date, the electronic progress notes indicated that resident #008 had told RPN #118 that they wanted to leave the building and that the RPN should have reassessed the resident at that time to determine their current elopement risk but, this did not occur.

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 each 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; (b) the resident’s care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 13th day of September, 2019

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

Original report signed by the inspector.