Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 11, 2019	2019_680687_0035	018792-19, 019286-19, 019972-19, 020325-19, 022222-19, 022775-19	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

LOVIRIZA CALUZA (687), SHELLEY MURPHY (684)

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): December 2 to 6, 2019.

The following intakes were inspected during this Critical Incident Systems (CIS) inspection:

- One CIS intake related to staff to resident neglect;

- Two CIS intakes related to resident to resident alleged abuse, and

- Three CIS intakes related to residents' fall that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Manager (RCM), Program Coordinators (PCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), residents and their families.

The Inspectors also conducted a daily tour of the resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.

A complaint inspection was conducted concurrently with this Critical Incident System inspection.

PLEASE NOTE: A non-compliance of a Voluntary Plan of Correction (VPC) related to s. 6(7) of the LTCHA 2007 was identified in this inspection and has been issued in Inspection Report #2019_680687_0036, which was conducted concurrently with this inspection.

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

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	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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident which caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A Critical Incident (CI) report was submitted to the Director on a specific day regarding resident #006's fall incident which resulted in an injury to the resident that occurred five days before.

Inspector #687 reviewed the CI report submitted to the Director regarding resident #006's fall incident and it was identified that the CI report was initiated at a later date.

During a review of the home's policy titled "Documentation: Report of Critical Incidents" last reviewed on September 5, 2019, it indicated that "In compliance with the LTCH Act, 2007; Reg 79/10, s 107, Pioneer Manor will ensure that the Director [under the Act] was informed, of the following incidents no later than one business day after the occurrence of the incident: An injury in respect of which a person was taken to a hospital and that resulted in a significant change in a resident's health condition".

In a review of the Registered Nurse (RN) Supervisor's Shift to Shift Report on a specified date, it indicated that resident #006 had an unwitnessed fall and an update was obtained by RN #127 the same date indicating the fall resulted in a significant change in the resident's health condition after being taken to a hospital.

During an interview conducted by Inspector #687 with Program Coordinator #116, they stated that they were assigned to expand their home area coverage which included the specified home area where resident #006 resided. The Program Coordinator further stated that they were supposed to read the RN Supervisor's Shift to Shift Report but they did not. The Program Coordinator acknowledged that they were unaware of the resident #006's fall incident which resulted in an injury; therefore, it was not reported to the Director within one business day. [s. 107. (3) 4.]

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.