Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Mar 16, 2020	2020_794749_0006	001412-20, 003252-20	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)

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): March 2 to 5, 2020.

The following intakes were inspected during this Critical Incident (CI) Inspection:
-One intake related to an allegation of staff to resident abuse; and,
-One intake related to an unaccounted controlled substance.

A Follow Up Inspection #2020_794749_0005 was conducted concurrently with this inspection.

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

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

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

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001, as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director on a specific day related to an allegation of staff to resident neglect. The CIS report indicated that resident #001 did not receive care by PSW #101 which was reported to staff by resident #001 the following day.

The CIS report further indicated that PSW #101 believed that resident #001 was independent. They confirmed to the RN that they had not assisted the resident. PSW #101 had also falsified documentation within the resident's medical record indicating they had provided an identified level of assistance for various activities of daily living (ADLs) for resident #001 however, the resident performed their own care.

Inspector #749 reviewed sections within the care plan for resident #001 that was in place at the time of the incident which indicated the level of ADL assistance resident #001 required.

Inspector #749 reviewed the resident #001's electronic medical record for the specific date and time of the incident. PSW #101 had documented that a different level of assistance was provided for specific ADLs than what the resident required.

A review of the home's investigation file indicated that a meeting occurred between RCC #108 and PSW #101 to discuss the allegation. During the meeting RCC #108 questioned PSW #101 if care was provided to resident #001 as per their plan of care. PSW #101 indicated that they had "received a run through on the resident" from another staff member. The electronic medical record documentation was reviewed, and the RCC questioned if the care was provided to resident #001, PSW #101 said it was not.

Inspector #749 reviewed the home's policy titled "Documentation Resident Care Plan" last revised on September 2, 2018. Under Procedure: Resident Kardex it indicated "All PSWs are to review the Kardex on the Point of Care (POC) tablet for each of their assigned residents prior to providing any care. All care/interventions are to be documented immediately after care given using tablets or kiosks. The health care provider that provides the care must document in the resident's POC record."

Inspector #749 interviewed PSW #101 who indicated that they took a verbal report from another staff member and did not review the care plan for resident #001 prior to providing care. The PSW indicated they reviewed the care plan the follow shift after the resident had brought their concerns forward. When the PSW was asked why they documented

false information into the resident's electronic medical record the PSW could not remember why.

In an interview with RCC #108, they indicated to Inspector #749 that PSW #101 did not provide care as specified in the plan of care to resident #001, and that the PSW also falsified documentation within the resident's electronic medical record. [s. 6. (7)]

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 care set out in the plan of care is provided to all residents, as specified in the plan, to be implemented voluntarily.

Issued on this 16th day of March, 2020

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

Original report signed by the inspector.