Ontario

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
Jul 14, 2020	2020_657681_0007	004017-20, 004760-20, 004973-20, 005543-20, 007338-20, 008955-20, 010144-20, 011849-20, 012794-20	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

STEPHANIE DONI (681), AMY GEAUVREAU (642), SYLVIE BYRNES (627)

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): July 6-10, 2020.

The following intakes were completed during this Critical Incident inspection:

- One intake related to a resident to resident altercation.

- Five intakes related to falls that resulted in injury to the resident and transfer to hospital.

- Two intakes related to allegations of staff to resident abuse or neglect.

- One intake related to a missing or unaccounted for controlled substance.

A Follow up inspection, #2020_657681_0006, and a Complaint inspection, #2020_657681_0008, were conducted concurrently with this inspection.

PLEASE NOTE - One intake was related to the same issue as was identified in a complaint, and was inspected on during concurrent Complaint inspection #2020_657681_0008.

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

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident records and policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of staff to resident neglect. The CIS report indicated that it was suspected that resident #006 did not receive a specified type of care from HCA #136, despite reminders by the unit RPN and another HCA.

Inspector #681 reviewed resident #006’s care plan that was in place at the time of the incident, which identified that resident #006 was to receive a certain type of care at specified intervals throughout the day.

The Inspector reviewed the resident’s point of care (POC) documentation and identified that there was no documentation to indicate that the specified care had been provided for the date and time that the CIS report was submitted to the Director.

During an interview with RPN #119, they stated that a HCA reported to them that resident #006 had not been provided with the specified care that they required. RPN #119 also stated that they reminded HCA #136 that they had to provide resident #006 with the specified care. RPN #119 identified that when the next shift started, that HCA also reported that resident #006 had not been provided with the specified care.

The Inspector reviewed the home's investigation notes related to the incident, which included documentation from a meeting that was held between RCCs #102 and #118, and HCA #136. The documentation from this meeting identified that HCA #136 indicated that resident #006 was provided with the specified care, but that the HCA did not document this care.

During an interview with RCC #134, they indicated that the expectation was that if a staff member assisted a resident with the specified type of care, there would be POC documentation to reflect each time the resident was assisted with this care. [s. 6. (9) 1.]

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 has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, the policy or protocol was complied with.

In accordance with Ontario Regulation 79/10, s.114 (2), the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction, and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee’s policy titled "Medication Administration: Controlled Substances", last revised May 12, 2019.

The Inspector reviewed the home’s policy titled "Medication Administration: Controlled Substances", which indicated that if a discrepancy was identified on a controlled substance record, the RN Supervisor was to be notified so that they could assist with the investigation and staff members were not to the leave the home area until this had been done. The registered staff member was also to complete a “Medication Incident” report.

A CIS report was submitted to the Director regarding a missing or unaccounted for controlled substance. The CIS report indicated that RN #132 was reviewing a resident's controlled substance record and noted that RPN #122 adjusted down the count for one of the resident's medications.

During an interview with RPN #122, they stated that they were reviewing the resident’s controlled substance card and noticed that there was one tablet missing. RPN #122 stated that they thought they had not counted down when they administered the resident's last medication dose so they counted down by one so that the record would match what was in the controlled substance card.

The Inspector reviewed a letter that was issued to RPN #122, which indicated that during the home’s investigation, RPN #122 was instructed that they could not manually adjust the narcotic record without notifying a supervisor, as there was a process to follow regarding potentially missing controlled substances.

During an interview with Resident Care Coordinator #103, they stated that the controlled substance count should not have been adjusted down without reporting this to a supervisor or manager. [s. 8. (1) (b)]

Issued on this 27th day of July, 2020

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

Original report signed by the inspector.