Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 9, Sep 30, Oct 3, 5, 6, 2011	2011_056158_0009	Critical Incident

Licensee/Titulaire de permis

THE 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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN),Registered Practical Nurse (RPN), Personal Support Workers (PSW) and families

During the course of the inspection, the inspector(s) reviewed residents's health care records, the critical incident reports sent to the Ministry of Health and Long Term Care(MOHLTC), policies and procedures related to fall prevention, head injury routines, emergency routines and abuse.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for a resident set out clear direction to staff and others who provide direct care to the resident.
2. A resident's health care record was reviewed by the inspector on August 10/11. The resident's progress notes identified a change in the resident's cognition status as well as identifying new responsive behaviours. The progress notes identified that an escalation of these new behaviours placed the resident at risk of actual harm 17 days later.
3. The resident's plan of care was reviewed by the inspector on Aug.10/11. The plan of care's review start date is identified as two month prior to the start of the resident's new responsive behaviours. The date of completion is 24 days after the resident was at risk of actual harm.
4. The resident's new responsive behaviours were not identified in the resident's written plan of care.
5. Clear direction to staff and others who provide direct care was not set out in the resident's written plan of care

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 written plan of care for all residents set out clear direction to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 23(2) in that it failed to ensure that the results of the investigation into the improper or incompetent treatment of a resident that resulted in harm or risk of harm was reported to the Director.
An incident of resident mistreatment by a PSW was not reported immediately to the Director by the Program Coordinator. The mandatory report submitted identified that the outcome of the investigation was pending. The Director of Care confirmed during the August 10/11 interview with the inspector that the results of the investigation was not reported to the Director as the investigation was not completed.
2. The licensee failed to comply with LTCA s. 23(1)(a) ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated.
An alleged report of resident mistreatment by a PSW was reported to the Program Co-ordinator.
On August 9/11, the inspector spoke with the Program Co-ordinator who stated that discussion with the resident and with the staff member involved occurred. The Program Coordinator identified that the resident's vital signs and neurological signs were not completed by them.
The RPN and a PSW working on the resident's unit at the time of the incident identified that they were not aware of the incident when interviewed by the inspector on August 10/11.
On August 10/11, the inspector spoke with the RN working at the time of the incident. The RN stated that they were not informed of the incident or that the resident had a physical repercussion as a result. The RN stated that when a resident hits their head, the resident would be assessed, and monitoring per head injury would continue. Documentation would be entered into the resident's progress notes which would then be generated into the 24-hr report.
The resident's progress notes were reviewed by the inspector on August 10/11. An assessment of the resident related to this incident was not found.
The 24-hr report from the resident's unit was reviewed by the inspector on August 10/11. There was no documentation in the 24-hr report identifying that the resident was assessed for injury post allegation of mistreatment.

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 every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated and that the results of the investigation is reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O Reg s. 53(4)(c) ensuring that the actions taken for a resident demonstrating responsive behaviour included assessment, reassessment, interventions and documentation of the resident's response to the intervention.
2. A resident health care record was reviewed by the inspector on August 10/11. The resident's progress notes identified a change in the resident's cognition status as well as identifying new responsive behaviours. The progress notes identified that an escalation of these new behaviours placed the resident at risk of actual harm 17 days later.
3. The resident's quarterly assessment was reviewed by the inspector on Aug 10/11. Responsive behaviours were not identified in this assessment. A reassessment was not completed after the incident when the resident's responsive behaviour put them at risk.
4. The home's " 15 min, half hour, hourly check " protocol was reviewed by the inspector on August 10/11. The protocol identified that the PSW document on a check form, the time, the date and the resident's response during the observation. The protocol also identified that the Registered staff initial the check form at the end of shift.
5. Safety monitoring checks every half hour for the resident were started when the resident first exhibited responsive behaviours. The half hour entries on the check form were completed by the PSWs for one week. The accountability initials of the Registered staff were not written for five of these seven days.
6. The PSWs half hour entries on the check form for three shifts of a second week were blank.
7. As well the Registered staff's accountability initials were not written for four day shifts and five evening shifts of the second week.
8. There was no accountability initial by the Registered staff written for the monitoring checks on the day the resident's responsive behaviour put them at risk of actual harm.
9. Actions to respond to the resident's responsive behaviours were not consistently taken.

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 actions are taken for all residents demonstrating responsive behaviour include assessment, reassessment, interventions and documentation of the resident's response to the intervention, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O Reg. 97(1)(a) ensuring that the resident's SDM and any other person specified were notified immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident.
An alleged incident of staff to resident abuse was reported to the MOHLTC by the Program Co-ordinator.
Allegedly, a PSW threw a resident against the wall when the PSW was assisting with the care needs of the resident. The resident's Power of Attorney (POA) was called by the inspector on Aug 10/11. The POA identified that they were not immediately informed of the incident. The POA also identified that the resident's alternate contact was not notified.
The resident's progress notes were reviewed by the inspector on August 10/11 and identified that the Program Coordinator only contacted the POA nine days post incident.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA s.20(1) in that it failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.
2. The home's abuse policy titled "Abuse: Resident Abuse/Mistreatment" was reviewed by the inspector on August 10/11. It states under section "Responsibility of the Home" (5.2) that the resident's substitute decision maker is notified of the alleged abuse immediately; the implicated staff is informed of the allegation; a date and time for discussion of the incident is set with the implicated staff member and his/her bargaining agent, if appropriate; and notify the implicated staff member in writing of any further action that will be taken.
3. A resident's POA was called by the inspector on Aug 10/11. The POA identified that they were not informed of the alleged mistreatment of the resident until nine days post incident. The POA also identified that the alternate contact was not notified.
The resident's progress notes identified that the Program Co-ordinator only contacted the POA nine days post incident.
4. The PSW involved in the incident stated during the August 12/11 interview with the inspector that it was not clear that an allegation of resident mistreatment was brought against them when the Program Coordinator questioned them.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 24(1) in that improper or incompetent treatment of a resident that resulted in harm or risk of harm was not immediately reported to the Director.
2. A mandatory report of improper care/mistreatment of a resident was reported to the Director by the Program Coordinator,however, the incident was not immediately reported.

Issued on this 5th day of October, 2011

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