**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Aug 11, Oct 5, 14, Dec 8, 15, 2011 | 2011_056158_0010 | Follow up |

**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 Follow up inspection.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Program Coordinators, Personal Support Workers (PSW), the Occupational Therapist (OT) and residents**

**During the course of the inspection, the inspector(s) reviewed residents' health care records, observed staff practices and interactions with residents.**

**The following Inspection Protocols were used during this inspection:**

**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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**

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. On August 11/11, the inspector observed that a resident approached the RPN for medication in a wheelchair. The inspector observed that total physical assistance of one staff was provided during the resident's transfer from their wheel chair to the bed.
The resident's printed plan of care which is accessible to staff who provide direct care identified that the resident's transferring assistance was "intermittent supervision with limited physical assistance". The resident's progress notes identified that the resident had increased difficulty standing and walking. On three separate days, the resident's progress notes identified the resident's need of one staff's total assistance for all transfers and toileting needs. There were also two recorded falls.
The resident's increased level of assistance was documented on the computerized plan of care, however, staff providing direct care to the resident do not have access to this.
The resident's progress notes identified the resident's use of a wheel chair to self-propel. The resident's printed plan of care, which is accessible to staff who provide direct care, identified the resident's use of a walker for mobility assistance and did not identify the use of a wheel chair. The resident's need of a wheel chair was documented on the computerized plan of care, however, staff providing direct care to the resident do not have access to this.
The resident's printed plan of care, which is accessible to staff who provide direct care, identified the intervention "ensure walker is within reach at all times". The resident's progress notes identified interventions such as a raised toilet seat, the use of a wheel chair and the safety interventions related to the operation of a wheel chair. These interventions were not documented in either the printed or computerized plan of care.
The licensee did not ensure that the written plan of care set out clear direction to staff and others who provide the resident's direct care.
[LTCHA 2007, S.O. 2007, c. 8, s.6 (1)(c)]

***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 all written plans of care which are accessible to the staff who provide the resident's direct care set out clear direction to the staff, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

**Specifically failed to comply with the following subsections:**

**s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,**
**(a) the resident's care needs change;**
**(b) the care set out in the plan is no longer necessary; or**
**(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).**

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**Findings/Faits saillants :**

1. A resident fell in their room while attempting to self-toilet. The resident had received specialized treatment at the hospital the day before. The resident's progress notes identified that increased complaints of nausea, generalized malaise, weakness and increased periods of urinary stress incontinence. The resident did have a previous fall without injury when the resident attempted to self-toilet.
A post fall assessment was completed which identified that the resident was attempting to self transfer onto the toilet. A re-assessment was not completed when the resident started the specialized treatments.
The resident's printed plan of care which is accessible to staff who provide direct care identified the following; " transfers without assistance", "toilets self without any assistance from staff", and "is continent" of urine. The resident's plan of care does not identify the diagnosis related to the resident's need for progressive therapy nor the interventions related to the treatment's side effects.
The licensee did not ensure that the resident was reassessed and the resident's care plan revised when the resident's care needs changed.
[O. Reg. 79/10, s. 24 (9)(a)]

***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 all residents are reassessed and their plans of care are revised when their care needs change, to be implemented voluntarily.***

**Issued on this 10th day of January, 2012**

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