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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 3, 2022 | 2022_805638_0001 | 000646-22 | 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

RYAN GOODMURPHY (638)

## 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): January 24 - 27, 2022.**

**The following intake was inspected upon during this Critical Incident System inspection;**
**-One log related to an unexpected death of a resident.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Resident Care Coordinator, Infection Prevention and Control Lead, Manager of Physical Services, Food Service Supervisor, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Nutrition Aides, Housekeepers and residents.**

**The Inspector also conducted daily tours of resident care areas, reviewed relevant health care records, internal investigation notes, policies and procedures, observed staff to resident interactions, the implementation of infection prevention and control practices, as well as the provision of care and dietary services to residents within the home.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Personal Support Services**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>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:**

**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 resident received their required meal interventions as laid out within their plan of care.

The resident was to have a special dietary intervention as per their plan of care. On one occasion the resident received their meal and did not have the appropriate interventions implemented.

The failure of staff to provide the resident with their planned dietary interventions resulted in actual harm to the resident.

Sources: The resident's care records; and interviews with a Resident Care Coordinator and other staff. [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 to ensure that residents receive their assessed dietary requirements as laid out within their plan, including any special interventions required to eat safely, to be implemented voluntarily.***

**Issued on this 3rd day of February, 2022**

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

**Original report signed by the inspector.**