Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
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Original Public Report

Report Issue Date June 3, 2022
Inspection Number 2022_1576_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
City of Greater Sudbury

Long-Term Care Home and City
Pioneer Manor, Sudbury

Lead Inspector
Shannon Russell #692

Inspector Digital Signature
Shannon K Russell
Digitally signed by Shannon K Russell
Date: 2022.06.17 15:24:14 -04'00'

Additional Inspector(s)
Amy Geauvreau #642, Karen Hill #704609, Christopher Amonson #721027

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 16-20, 2022.

The following intake(s) were inspected:

- One intake of a complaint related to a family member's refused entry into the home.
- One intake related to an unexpected death of a resident
- Two intakes related to an allegation of visitor to resident abuse
- Two intakes related to an allegation of resident neglect
- Two intakes related to an injury that caused a significant change in health status
- Three intakes related to an allegation of staff to resident abuse
- Four intakes related to missing/unaccounted for controlled substances

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours

INSPECTION RESULTS

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NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021, s. 6 (1) (c).

The licensee has failed to ensure that there was a written plan of care for a resident, that provided clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident's electronic health record was reviewed, which identified the resident's Level of Care Wishes. Documentation in the progress notes indicated a different level of care was being provided. Additional review of the resident's paper chart revealed that the resident's level had changed.

A Registered Practical Nurse (RPN) acknowledged that when the resident's level of care had changed, that the plan of care and clinical record should have been updated to reflect that.

After speaking with the inspector, the RPN immediately contacted their nursing supervisor who updated the resident's electronic plan of care to reflect their current level of care, as outlined in the physician's orders.

There was no impact and low risk to the resident as the staff were providing the identified level of care as required and consistent with the preference of the resident.

Sources: Critical Incident (CI) report; a resident's health records; and interviews with RPN and Resident Care Coordinator (RCC).

Date Remedy Implemented: May 19, 2022 [704609]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 19 (1) (a)

The licensee has failed to ensure that a resident was protected from physical abuse by a PSW.

Rationale and Summary
A CI report was submitted to the Director by the home, which described care concerns related to a resident transfer by a PSW, which resulted in injury to the resident.

Ontario Regulation (O. Reg.) 79/10 of the Long-Term Care Homes Act (LTCHA), 2007, defines physical abuse "as the use of physical force by anyone other than a resident that causes physical injury or pain".

A resident reported to the home that when a specific PSW transferred them on two consecutive dates, the PSW had had been rough during the transfer, which resulted in an injury to the resident. The resident indicated that when they had told the PSW that they had been rough with the resident, the PSW laughed.

At the time of the inspection, the resident and a RCC further verified that the PSW had not transferred the resident correctly and was rough when doing so, which resulted in the resident being injured. The RCC indicated the home defined the way the PSW transferred the resident as abuse given the resident was injured. As on two consecutive dates the PSW did not take the proper actions to fix the situation or notify someone and did not check the resident's plan of care to determine what was required specific to safe transferring of a resident.

Sources: CI report; a resident's care plan and assessments; the home's policy titled, "Abuse: Resident Abuse/Neglect", last reviewed May 4, 2022; the home's investigation notes; a letter addressed to the PSW; and interviews with the resident, the RCC, and other staff. [704609]

WRITTEN NOTIFICATION: POLICIES AND RECORDS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 8 (1) (b)

The licensee failed to ensure that where the Act or Regulation required the licensee to have, institute or otherwise put in place any policy or procedure, the policy and procedure was complied with for two residents.

Rationale and Summary
In accordance with O. Reg. 79/10, s. 49 (1), the licensee was required to ensure that the Falls Prevention and Management Program provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff had not complied with the home's policy, which indicated that, all residents were to be assessed and monitored using a specified document according to the home's established protocol.

a) A resident had sustained multiple unwitnessed falls within a five-month period; a specified document was initiated with each fall. For three of the fall incidents, the specified document record was not completed in its entirety.

b) Another resident had sustained an unwitnessed fall, and the specified document had been initiated, but not fully completed.

A RPN and a RCC acknowledged that the registered staff were expected to complete and document the required monitoring on the specified document as outlined in the home's policy.

Failing to ensure that the specified document was completed as required for the two residents may have put the residents at risk by delaying the identification of changes in their condition and the implementation of additional care interventions as needed.

Sources: CI reports; review of two resident's health records and specified documents; the home's policy titled, "Head Injury Protocol", last revised, March 2, 2020; and interviews with a RPN, and the RCC. [704609]

WRITTEN NOTIFICATION: POLICIES AND RECORDS

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 8 (1) (b)

The licensee failed to ensure that where the Act or Regulation required the licensee to have, institute or otherwise put in place any policy or procedure, the policy and procedure was complied with for a resident.

Rationale and Summary
In accordance with O. Reg. 79/10, s. 49 (1), the licensee was required to ensure that the Falls Prevention and Management Program provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff had not complied with the home's policy, which indicated that the post fall management of residents included the completion of a specified assessment, to be documented in the progress notes in the electronic health record.

A resident had sustained two fall incidents on two separate dates, and the specified assessment had not been completed for either of the incidents.

Registered staff members and the RCCs all verified that a specified assessment must be completed by a registered staff member for every resident fall incident.

By not completing the specified assessment after every fall incident, posed an increased risk to the resident, related to lack of clinical assessment and information gathered after the fall incident, and any appropriate falls prevention interventions that should have been implemented.

Sources: CI report; review of a resident's health record; the home's policy titled, "Falls and Fall Related Injuries: Assessment, Reduction & Management", last revised April 7, 2021, and "Post fall process" checklist, dated June 17, 2020; and interviews with a RPN, a RN, and a RCC. [704609]

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WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, r. 36.

The licensee has failed to ensure that direct care staff used safe transferring techniques while transferring two residents.

Rationale and Summary
a) A resident's plan of care at the time of the incident, indicated that their transfer status required staff to use a specified transfer device, with specific staff assistance.

On two consecutive dates, the PSW transferred a resident without the required transfer device, which resulted in the resident being injured. The PSW indicated that they had difficulty transferring the resident; however, they had not reported the difficulties to the registered staff.

b) Another resident's plan of care at the time of the incident indicated that they required a specified transfer status for all transfers. A PSW had transferred the resident using a specific transfer device on several occasions, that was not in the resident's plan of care.

Additionally, documentation of care provided to the resident for a 30-day period, specific to transfers, indicated that several staff members had transferred the resident not utilizing the proper transfer method on many occasions.

The home's policy titled, Minimal Lift Program, indicated that all staff were to adhere to the designated lift/transfer status as identified in each resident's plan of care, and that any change in a resident's mobility status, or any other untoward issue, was to be reported to the registered staff immediately.

Staff members and management all verified that staff were always required to follow the resident's plan of care specific to transferring; that not doing so posed a safety risk to the resident and would not be complying with what was required by the home.

Sources: Two resident's care plan and assessments; the home's "Minimal Lift Program" policy, last reviewed October 29, 2020; the home's investigation notes; a letter addressed to the PSW; and interviews with the resident, a RPN, a RCC, and other staff. [704609]