Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: April 3, 2023

Inspection Number: 2023-1576-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: City of Greater Sudbury

Long Term Care Home and City: Pioneer Manor, Sudbury

Lead Inspector	**Inspector Digital Signature**
Shelley Murphy (684)	Shelley Murphy Digitally signed by Shelley Murphy Date: 2023.04.05 11:35:54 -04'00'

Additional Inspector(s)
Ryan Goodmurphy (638)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 6-10, 13-15, 2023

The following intake(s) were completed in this inspection:

- Four intakes, related to falls;
- Two intakes, related alleged verbal abuse of a resident;
- Two intakes, related to alleged sexual abuse of a resident;
- Three intakes, related to abuse/neglect of a resident;
- Five intakes, related to missing/unaccounted for controlled substances.
- One Intake, related to a missing resident;
- One complaint related to a resident fall; and,
- One complaint related to resident care.

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

Resident Care and Support Services
Medication Management

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee failed to ensure that when a staff member received a report of alleged abuse, they immediately reported the suspicion and the information upon which it is based to the Director.

The Critical Incident (CI) report noted the date of the CI submission, however; the date of the alleged abuse occurred several days earlier. None of the dates of the alleged abuse were immediately reported to the Director.

The investigation notes stated a staff member informed a superior staff member that another staff allegedly abused a resident when providing care. The staff member who this was reported to did not report the allegation of abuse that was brought forth to them.

During an interview with the Manager of Resident Care (MORC), they stated that the expectation was that alleged abuse was reported immediately, and it was not.

There was no risk to the resident related to this non-compliance.

Sources: CI report, home's investigation notes, the home's policy titled: "Abuse: Resident Abuse/Neglect" last review May 4, 2022, interviews with MORC and other staff.
[684]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

During a review of the CI report there was a concern that was brought forth which stated when a resident was being transferred the correct interventions were not utilized.

The home responded to the concern and stated they had followed up with the staff member involved and resident specific interventions would be used when transferring the resident.

The resident's care plan was reviewed for transfer and mobility, neither care plan focus indicated that the specific intervention was to be utilized when performing a transfer.

The inspector observed two staff members transferring the resident, it was noted that neither staff member utilized the appropriate intervention. They both stated they do not use that intervention.

The Manager of Resident Care stated resident's interventions are to be utilized during transfers and this should be in their care plan.

Risk to resident related to this non-compliance was low.

Sources- CI report, complaint letter and complaint response letter, the resident care plan, and interviews with staff and the MORC. [684]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a staff member used safe transferring techniques when they were assisting a resident.

A staff member was transferring a resident when an incident occurred. The staff member did not use the correct transfer intervention as identified in their care plan or follow proper transfer techniques. As a result of the incident the resident had a change in condition.

Staff failed to ensure safe transferring techniques where followed when they chose the incorrect

intervention, which resulted in moderate harm to the resident.

Sources: Resident health care records including their Minimum Data Set, care plan and progress notes; the home's policies titled: "Safe Operating Procedure Mechanical Floor Lift Transfers" last revised August 22, 2018, and "Safe Operating Procedure Standard Sling Guidelines and Application" issue date August 22, 2018; written warning to the staff member; and interviews with staff. [638]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff who provide direct care to the resident related their mobility.

On a specified date, it was determined that the resident would benefit from a specific mobility aid intervention. The resident's care plan was updated but did not provide clear directions to the staff at this time.

On a later date, the resident was being assisted with their mobility aid by a staff member when an incident occurred. The staff member identified that they were unaware of the potential for an incident to occur as this was not laid out within the resident's care plan at the time of the incident. After the incident the resident's care plan was updated with clear directions for staff to follow.

Staff failed to update the resident's plan of care to provide clear direction to those who provided direct care to the resident related to their mobility aid. This posed a moderate risk and harm to the resident at the time of the incident.

Sources: Resident's health care records including their Minimum Data Set, care plan and progress notes; the home's policy titled: "Pioneer Manor Wheelchair Safety" last revised January 26, 2023; interviews with MORC and other staff. [638]