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: September 7, 2023

Inspection Number: 2023-1576-0004

Inspection Type:
Critical Incident

Licensee: City of Greater Sudbury

Long Term Care Home and City: Pioneer Manor, Sudbury

Lead Inspector	**Inspector Digital Signature**
Barbara Humenjuk (000741)	Barbara Humenjuk Digitally signed by Barbara Humenjuk Date: 2023.09.25 10:41:30 -04'00'

Additional Inspector(s)
Jessamyn Spidel (000697)
Tracy Muchmaker (690)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21 to 25, 2023.

The following intake(s) were inspected:

- Intake: related medication incident/adverse drug reaction;
- Intake related to Improper/incompetent care of a resident;
- Intake related to an unexpected death of a resident;
- Intake related to improper/incompetent care of a resident;
- Intake related to physical abuse of a resident by staff; and
- Intake related to controlled substance missing/unaccounted.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident, immediately reported the suspicion to the Director.

Rationale and Summary
An incident involving an improper transfer of a resident was not immediately reported to the Director.

Resident Care Coordinator (RCC) confirmed that the incident was reported to the Director late.

Sources: Interview with RPN, and RCC; Policies including: Abuse: Resident Abuse/Neglect Home last reviewed/revised on June 27, 2023, Documentation: Critical Incident Report; and the home's internal investigation file related to this incident. [000697]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Rationale and Summary
The resident's care plan in effect at the time of the incident indicated transfers were to be completed in a specific manner.

The home's internal investigation file related to this incident confirmed that the transfer was not

completed as per the resident's care plan or the home's policy.

The risk at the time of the incident was identified as moderate.

Sources: Care Plan and progress notes for resident; Interview with resident , PSW's, and RCC; Home policies including: Minimal Lift Program; Critical Incident Report; and the home's internal investigation file related to this incident. [000697]

2.

A PSW failed to use safe transferring and positioning techniques, when assisting a resident.

Rationale and Summary
The home's investigation file related to this incident confirmed that the PSW failed to use safe transferring techniques.

The risk at the time of the incident was identified as moderate due to the potential risk of injury.

Sources: Care Plan and progress notes for resident; Interview with PSW"s ; Home policies including: Minimal Lift Program; Critical Incident Report; and the home's internal investigation file related to this incident. [000697]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug was used by or administered to a resident unless the drug had been prescribed for that resident.

Rationale and Summary
A medication incident note and progress notes identified that a resident was administered a medication that was not prescribed to them.

The RPN verified that they had administered the medication in error to a resident, as they did not follow proper medication administration procedures.

The impact to the resident was moderate.

Sources: Resident's progress notes, a medication incident report, and investigation notes; interviews with RPN, and Resident Care Coordinator (RCC).
[690]

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