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: March 26th, 2024

Inspection Number: 2024-1576-0001

Inspection Type:
Critical Incident
Follow up

Licensee: City of Greater Sudbury

Long Term Care Home and City: Pioneer Manor, Sudbury

Lead Inspector	**Inspector Digital Signature**
Justin McAuliffe (000698)	Justin Christopher Mcauliffe Digitally signed by Justin Christopher Mcauliffe Date: 2024.03.26 13:50:55 -04'00'

Additional Inspector(s)
Ryan Randhawa (741073)
Oraldeen Brown (698)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11-14, 2024
The following intake(s) were inspected:

- One intake related to the improper care of a resident.
- One intake related to the improper care of a resident.
- One intake related to an Influenza A Outbreak.
- One follow-up intake CO #001 related to suction equipment.
- One follow-up intake CO #002 related to medication administration.
- One intake related to an Acute Respiratory Infectious Outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1576-0005 related to O. Reg. 246/22, s. 96 (2) (a) inspected by Justin McAuliffe (000698)

Order #002 from Inspection #2023-1576-0005 related to O. Reg. 246/22, s. 140 (1) inspected by Justin McAuliffe (000698)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary:
Review of the home's internal investigation notes related to an alleged improper transfer revealed that a Personal Support Worker failed to safely transfer a resident.

The home's safe lifting and care program stated that two trained staff were required at all times when performing a mechanical lift transfer.

During an interview with the Resident Care Coordinator (RCC), they acknowledged that the PSW performed an unsafe transfer as they did not follow the home's policy requiring two staff for all mechanical lift transfers.

The PSW's failure to follow the home's policy requiring two staff for all mechanical lifts placed the resident at risk for injury.

Sources: The home's internal investigation notes, the home's Minimal Lift program, interviews with RCC and other relevant staff. [698]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee failed to ensure that a resident's individualized continence plan of care was implemented.

Rationale and Summary
A resident was assisted with continence care on the toilet by a Personal Support Worker (PSW). The PSW left the resident on the toilet to attend to another resident whose alarm sounded. When the PSW returned to assist the resident, the resident had sustained a fall.

The resident required constant supervision with continence care and toileting, as indicated in their plan of care.

The PSW confirmed that they did not provide constant supervision to the resident and indicated that they should have stayed with the resident and provided constant supervision with continence care and toileting, as specified in the resident's plan of care.

Interviews with the management staff indicated that staff were expected to follow the plan of care and provide constant supervision to the resident for continence care and toileting.

The resident was at an increased risk of falls when their individualized continence plan of care was not implemented.

Sources: Clinical records; Interviews with staff. [741073]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:

4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that monitoring of a resident's response to, and the effectiveness of, the pain management strategies were completed.

Rationale and Summary
A resident experienced pain following an improper transfer incident. The Registered Practical Nurse (RPN) administered pain medication to the resident without completing a pain assessment before or after administering the medication.

There were no records of documentation in the resident's clinical record regarding the completion of a pain assessment before or after the incident.

The Director of Care (DOC) acknowledged that pain assessments should have been completed and documented in the resident's electronic chart.

Failure to assess the resident's pain delayed the identification of pain and that pain control issues were appropriately addressed and followed up with.

Sources: Clinical records, policy titled, "PAIN AND SYMPTOM MANAGEMENT PROGRAM" last revised February 2024 and interview with DOC. [698]