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
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Original Public Report

Report Issue Date: November 5, 2024

Inspection Number: 2024-1576-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: City of Greater Sudbury

Long Term Care Home and City: Pioneer Manor, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31, 2024 and November 1, 2024.

The following intake(s) were inspected:

- One complainant related to alleged improper care of a resident by staff;
- One intake related to the unexpected death of a resident;
- One intake related to an incident resulting in death of a resident;
- Follow-up to compliance order (CO) #01, issued in 2024-1576-0002 related to duty to protect;
- Two intakes related to alleged improper/incompetent care of resident by staff;
- One complainant related to a medication incident;
- One intake related to alleged neglect of resident by staff; and,
- Two intakes related to outbreaks of infectious disease.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1576-0002 related to FLTCA, 2021, s. 24 (1).

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care as set out in an identified residents plan of care, was documented. Following an incident, care was provided to the resident which was not documented.

Sources: The residents health file, the home's investigation file; and interviews with staff.

WRITTEN NOTIFICATION: Safe Lifts and Transfers

NC #002 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 an identified resident was transferred using safe techniques.

A staff member failed to remove an assistive device from the resident post transfer which resulted in injury to the resident.

Sources: Progress notes for the resident; internal investigation notes; and, interview with staff.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 4.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:

4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

The licensee has failed to comply with the home's policy, included in the required continence care and bowel management program, related to care for a specific resident.

In accordance with Ontario Regulation (O. Reg) 246/22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols developed for the continence care and bowel management program were complied with.

Specifically, a staff member completed care for the resident that was outside of their scope of practice.

Sources: Plan of care for the resident, the home's investigation file, the home's policy, and interviews with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. A Registered Staff member administered a resident's medications to a different resident in error.

Sources: Complaint intake, home's medication incident reports and the resident's progress notes.