Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'Inspection	Type of inspection/Genre d'inspection
Sep 11, 12, 13, 14, Oct 9, 10, 11, 2012	2012_140158_0013	Critical Incident

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

Long-Term Care Home/Foyer de soins de longue durée

PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

Name of inspector(s)/Nom de l'inspecteur ou des inspecteurs

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care, Program Coordinators, RAI Coordinator, Manager of Therapeutic Services, the Physiotherapist, Physiotherapy Aids, Registered Nursing Staff, Personal Support Workers, families and residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed a resident's health care record, reviewed various policies and procedures.

The following log was reviewed as part of this Critical Incident inspection: S-001023-12.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. In August 2012, staff # S-100 documented in resident # 01 progress notes that the resident was found on the floor on their buttocks, two bedrooms down from the resident's room. Staff S-100 documented that the resident did not have their Versus badge on when Staff-100 assessed the resident's vital signs post fall. The Program Co-ordinator identified that the "Versus Detail by Badge" system tracks the resident's badge location, the time into the location and the time out. A print out of the "Versus Detail by Badge" status identified that the resident's Versus badge was located in the resident's room at the time of the resident fall. It was documented on the "Versus Daily Check" list that resident # 01 Versus badge was missing at the time of the resident's fall. The plan of care identified that resident's Versus badge "is to be clipped to the resident's clothing at all times". The care set out in the plan of care was not provided to resident # 01. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (7)]

2. In July 2012, Staff # S-101 documented that "the raised toilet seat in resident # 01 bathroom is too high as the resident is having difficulty transferring on and off the toilet" and a referral to the Physiotherapist was sent. The Physiotherapist who initially assessed resident # 01 in July 2012 identified that a raised toilet was not an assessed need for resident # 01. The physiotherapist assessed the resident in August 2012 and documented in the resident's progress notes, the following," sign to be posted in bathroom that reads Raised Toilet Seat to be applied for toileting of resident # 2 only ". It was documented on resident # 01 computerized plan of care that resident # 01 "does not use a raised toilet seat". The care set out in the plan of care was not provided to resident # 01. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. In August 2012, staff # S-100 documented in resident # 01 progress notes that the resident was found on the floor on their buttocks, two bedrooms down from the resident's room. A Head Injury Routine (HIR) was initiated at that time. The HIR form was reviewed by the Inspector on September 11/12 and shows that the resident's vital signs were taken at the time of the incident, on day shift and on evening shift. The home's Head Injury Routine identified that the vital signs and neurological status of a resident with a suspected head injury is assessed immediately after the incident, in an hour and then once each shift X 24 hrs. Although,an initial assessment was commenced, the licensee failed to ensure that its Head Injury Routine (HIR) was followed in relation to the post fall assessment of resident # 01. Subsequent to this incident, the resident, fell again two days later and sustained a head injury. The resident was transferred to hospital and expired seven days later. The licensee did not ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls. [O Reg 79/10, s. 49.(2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any resident who falls is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 11th day of October, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs