Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 11, 2012	2012_138151_0018	S-00314-12	Critical Incident System

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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 27,28,29,30,2012

Inspection related to the following:
1- S-000314-12 related to CI: M566-000027-12
2- S-000279-12 related to CI: M566-000024-12
3- S-000970-12 related to CI: M566-000055-12
4- S-000855-12 related to CI: M566-000050-12
5- S-000569-12 related to CI: M566-000037-12
6- S-000671-12 related to CI: M566-000040-12
7- S-001136-12 related to CI: M566-000070-12

During the course of the inspection, the inspector(s) spoke with Manager of Resident Care, Program Coordinators, Registered Staff, Personal Support Workers (PSW), residents, family members

During the course of the inspection, the inspector(s) - observed care and service delivery to residents,
- reviewed the home's program in regards to falls prevention,
- reviewed the home's program in regards to the management of responsive behaviours,
- reviewed related policies and procedures
- reviewed residents' health care records,
- reviewed home's policy on abuse.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Medication

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has not ensured that every resident is afforded privacy in treatment and in caring for their personal needs. [LTCA,2007 S.O.2007,c.8, s.3.(1)8]

Resident 07 informed the Inspector of an objection to students observing and participating in required personal care. Resident stated that no one asked for permission for the student assignment. Resident mentioned the objection to the mentoring nurse teaching the students and was told;"well they have to learn somehow". Resident continues to be included in student assignments.

Inspector spoke with the RPN on shift who confirmed that no PSW mentor has mentioned the resident's objection to having students . [s. 3. (1) 8.]

WN #2: 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:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

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1. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [LTCHA 2007,S.O. 2007,c.8,s.6 (4)].

Inspector reviewed the post-fall assessments for three (3) residents. All of these were found to be incomplete according to the home's policy and procedure. Inspector noted that:
- in one (1) of three (3), the assessment did not identify "actions" taken,
- in one (1) of three (3), the assessment did not provide progress notes in regards to the incident and,
- in three(3) of three (3), there were no accountability signatures as required on the form that would indicate that the falls were reviewed by the management team.

Inspector interviewed staff person #0003 and pointed out the missing accountability signatures. This staff person stated that "we are far behind in these". [s. 6. (4) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has not ensured the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital.
[O.Reg.79/10,s.107.(3)4.]

Inspector reviewed Critical Incident Incident 70 and noted that this incident resulting in resident transfer to hospital was not reported to the Director for 6 days after the occurrence of the incident. Requirement for reporting to the Director is to be within one business day. Report was discussed with Staff #000021 who confirmed that the time line for reporting was exceeded.

Inspector 151 reviewed Critical Incident 24 referencing resident injury resulting in transfer to hospital. This incident was not reported to the Director until 3 days after the resident's transfer to hospital. Time line for reporting exceeded. [s. 107. (3)]

Issued on this 11th day of December, 2012

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

Monique G. Berger