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
May 2, 2013	2013_138151_0015	S-001266-12	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): March 15,16,17,18,19, 2013

This inspection reviewed the outstanding non-compliance orders:
CO LTCHA 2007, S.O. 2007, c.8, s.6 (c) issued September 13, 2012 (plan of care)
CO O.Reg.79/10,s.17(1) issued September 13, 2012 (resident communication and staff response system)
CO O.Reg.79/10,s.53 (4) issued September 13, 2013 (management of resident responsive behaviours)
CO O.Reg.79/10,s.50 (2) issued April 13, 2013 (skin and wound program

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care, Manager of Environmental Services, Nursing Managers, Registered Staff, Personal Support Workers (PSW), Wound Care Co-ordinator, Information Technologist, residents, families and visitors

During the course of the inspection, the inspector(s)
- directly observed resident care and services
- toured the home daily
- reviewed residents health care records
- reviewed the home's policies, procedures, protocols and quality assurance strategies in reference to the responsive behaviour program
- reviewed the home's policies, procedures, protocols and quality assurance strategies in reference to the skin and wound program
- reviewed the home quality assurance program
- audited the resident communication and staff response system
- audited resident records for post-leave skin and wound assessments

The following Inspection Protocols were used during this inspection:
Personal Support Services

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector interviewed staff about the resident's communication system and was advised that after 3 minutes, if the call had not been responded to, the call would be diverted to registered staff for attention.

On Pine Unit, Inspector observed that a resident call bell had been initiated in the resident's washroom. Inspector noted the computer at the nursing station had the correct resident location for the call. Inspector watched the room from the nursing station for staff's response to the call. After 15 minutes, Inspector interceded and asked to see RPN Staff #009's pager. Inspector confirmed the call had been diverted to and was registered on the pager. Staff #009 stated that Staff # 009 had ignored the resident call as Staff #009 did not want to interrupt the medication pass.
The resident did not receive care in a manner consistent with his/her needs [s. 3. (1) 4.]

2. Inspector noted the home had implemented a system of quick reference for staff that identified the residents with high risk responsive behaviours and the related interventions to apply. The posted information on these notices contained the following: resident's name, the high risk behaviour demonstrated and suggestions as to staff action to deal with these.
On April 17, 2013, on Cranberry Unit, Inspector observed the posted notice in the unit's open desk nursing unit area. This nursing unit is located in the hallway directly in front of the unit's dining room. The poster was visible to residents and visitors walking by the desk.

Discussion with Manager of Resident Care confirms that these posted notices are not to be brought out to the desk area but are meant for the closed staff report rooms.

The home did not ensure that resident information was kept confidential. [s. 3. (1) 11. iv.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

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COMPLIED NON COMPLIANCE ORDER(S) / REDRESSEMENT EN CAS DE NON RESPECT OU LES ORDERS

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #002	2012_140158_0015	151
O.Reg 79/10 s. 50. (2)	CO #001	2012_099188_0016	151
O.Reg 79/10 s. 50. (2)	CO #002	2012_140158_0005	151
O.Reg 79/10 s. 53. (4)	CO #003	2012_140158_0015	151
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2012_140158_0015	151

Issued on this 2nd day of May, 2013

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

Monique G. Berger (151)