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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2014	2014_140158_0008	S-078-14, S-0313	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

KELLY-JEAN SCHIENBEIN (158)

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): May 27-30, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, Program Managers, Registered staff (RN, RPN), Personal Support Workers (PSW), Physiotherapy staff, residents and Family members.

During the course of the inspection, the inspector(s) conducted tours of the home areas, reviewed various policies and procedures, observed the provision of care to residents by staff, observed resident/staff interactions and reviewed the health care records for several residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the care plan was based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator.
On May 27/14, the Inspector observed that resident # 05, who was resting in bed, had visible swelling. The resident was observed on May 28/14, sitting in a wheel chair (w/c) with their feet dragging on the floor. The resident complained to the Inspector that they had pain from sitting too long and from the increased swelling.
On May 27 and 28/14, the Inspector reviewed the home’s Falls Prevention Policy, progress notes and resident # 05's plan of care, which included assessments, care plan and kardex.
It is documented in the home’s Fall Prevention Policy, that a “Falls Risk Assessment “is conducted within 24-hrs of the resident’s admission and that an “over-bed assessment card" is posted identifying the resident’s risk to fall and the transfer assistance logo.
It was noted that a fall risk assessment was not completed. It was documented in the progress notes, that physiotherapy assessed the resident, however, the resident’s transfer assessment was not completed. There was no over-bed transfer logo posted for resident # 05.
The plan of care was dated prior to the resident's actual admission into the home. Staff # S-101 confirmed that the care plan was created prior to the resident’s admission with the information provided on the CCAC‘s assessment forms. Staff # S-101 added that the Registered staff on the unit are responsible for updating the care plan within 24-hrs, after the resident is admitted and when there are discrepancies with the CCAC information. Transfer interventions and generic fall interventions used in the resident's previous placement were documented in resident's plan of care.
On May 27/14, Inspector spoke with staff # S-102 who stated to the Inspector that the resident is transferred differently than what was documented on the care plan. Staff # S-102 added that the resident complained that they are uncomfortable when sitting in their w/c for long periods.
There was no indication that the resident # 05’s care plan was updated to reflect the resident’s current needs. The licensee did not ensure that the care set out in the care plan was based on an assessment of resident # 05 current needs, specifically the risk of falling. [s. 24. (4)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented for cleaning of the home, including resident bedrooms, including floors, and common areas and floors, contact surfaces and wall surfaces.
On May 27/14, the Inspector observed that the hallways in two units were littered with sand, grit and debris. A build-up of sand and grit was also observed at the entrance of resident's bedrooms. On May 28/14, the Inspector observed that the build-up previously observed remained.
On May 27, 2014, the Inspector observed that resident # 05's bedroom floor was littered with sand, grit and debris. The resident's bed was pushed aside and cardboard boxes were stacked on an over-bed table. It was identified by staff # 102 that resident # 05's roommate had been transferred, 2 hours before. The Inspector observed resident # 05 room in the same state of disarray on May 28/14 at 10:00h.
Procedures were not implemented for cleaning of the home and resident # 05 bedroom. [s. 87. (2) (a)]

2. On May 29/14, the Inspector observed that the patio/glass balcony in one unit was not clean. Bird droppings and build-up of debris was observed. The inspector spoke with resident # 12 and # 06, who stated that they would love to enjoy the nice weather by sitting on the balcony but given the present unkempt state, that they would not.
Procedures were not implemented for cleaning of the home and a common area. [s. 87. (2) (a)]

3. The Inspector observed that small black debris, resembling mouse droppings, were present in resident # 12's room. It was confirmed by staff # 03 and # 04 that the matter was reported to housekeeping. Rodent traps were put in place however, this room was not cleaned. Staff # 05 confirmed that this room had not been cleaned. [s. 87. (2) (a)]

Issued on this 16th day of June, 2014

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