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
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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
Oct 2, 2014	2014_283544_0021	S-000329-14	Resident Quality Inspection

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

FRANCA MCMILLAN (544), BEVERLEY GELLERT (597), JENNIFER LAURICELLA (542), MARINA MOFFATT (595), MONIKA GRAY (594), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 5, 6, 7, 8, 11, 12, 13, 14, 15, 2014 in relation to:

Log # S-000329-14
Log # S-000509-13
Log # S-000298-14
Log # S-000234-14
Log # S-000343-13
Log # S-000309-14
Log # S-000273-14
Log # S-000261-14

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care, Program Co-ordinators, Registered Staff, Personal Support Workers(PSWs), Manager of Physical Services, Material Control Supervisor, President of Resident Council, Resident Council Assistant, Chairperson of Family Council, Clinical Dietitians, Food Service Manager, Food Service Supervisor, Cook, Nutrition Aide, Housekeeping Aide, Laundry Aide and Documentation Registered Practical Nurse.

During the course of the inspection, the inspector(s) observed daily the delivery of care and services to the Residents, staff to Resident interactions, the delivery of meals and snacks to the Residents in different home areas, laundry services, medication administration to Residents in different home areas, reviewed Residents' health care records, progress notes, physician orders, care plans, kardexes, treatment records, medication records, policies and procedures regarding medication administration, Responsive Behaviours Program, Falls Prevention Program, Continence Care and Bowel Management Program, Skin and Wound Program, Infection Control Program, Recreation and Activities Program, Pain Management Program, Minimizing Restraints Policy, Prevention of Abuse and Neglect Policy, Residents' Council Meeting minutes, Family Council meeting minutes and process for Reporting of Complaints.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Inspector # 597 reviewed the health care record including the Resident's care plan, kardex and progress notes for Resident # 003 and identified that the plan of care stated that Resident # 003 had a medical device in situ.
Inspector # 597 interviewed Resident # 003 and found no medical device in situ. Resident # 003 stated to the Inspector that the medical device had been removed "sometime" ago.
Staff # 122 and Staff # 135 both confirmed that no medical device was in situ for Resident # 003. The plan of care did not identify that this medical device had been removed.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Inspector # 544 reviewed the progress notes and wound assessments for Resident # 016 and identified that Resident # 016 had a wound. The Registered Staff had been monitoring the wound.
There were no measurements of the wound documented for the weekly wound care

assessments for several weeks.
The interventions for the wound were weekly monitoring of the wound by the wound care team, turning of the Resident q 2 hourly and the use of a therapeutic cushion.
The wound was described by Staff # 147 as, "assessment completed for wound, continues to be boggy and the wound area was necrotic."
It was written in the care plan, regarding the pressure wound, " once debrided, the stage should then be implemented."
To date, there was no direction as to when the wound would be debrided and staged.
Staff # 117 confirmed that the plan of care did not give clear direction to staff regarding care for the wound. Staff # 117 initiated Wound Care Protocol (WCP) and revised Resident # 016's plan of care.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector # 544 reviewed the progress notes and wound assessments for Resident # 016 and identified that Resident # 016 had a wound.
The Resident stated to Inspector # 544 that they wanted "something done" to care for this wound and was afraid that this wound was not healing. Resident # 016 also stated, "this waiting and observing has gone on too long."
Inspector # 544 observed Resident # 016's wound to have an open area of skin and the wound was draining. Inspector # 544 reported this to Staff # 108 who was going to report this to Staff # 147, who was going to do the wound care at some point.

Resident # 016 complained of pain in their wound area to Inspector # 544 many times and stated the intensity of the pain was 10/10.
There was no focus, goals or interventions identified in regards to Resident # 016's pain management.
Inspector # 544 reported Resident # 016's pain to the Staff # 108, who then administered the medical directive for pain medication to Resident # 016.
This was confirmed by Staff # 117 and on August 13, 2014, Staff # 117 revised the plan of care to reflect the pain management and initiated Wound Care Protocol for Resident # 016's wound.

The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of Resident # 016. [s. 6. (2)]

3. Inspector # 542 interviewed Resident # 006. The Resident informed the Inspector that the staff were getting the Resident up too early and that they would like to sleep in longer in the morning. The Inspector reviewed the Resident's health care records and noted that the most current care plan indicated that the Resident preferred time to get up in the morning was 0900 hours. Inspector brought this information forward to Staff # 100. Staff # 101 informed the Inspector that an investigation was conducted and Staff # 100 concluded and confirmed that the staff did not follow the Resident's plan of care regarding the Resident's preferred time.

The licensee failed to ensure that the care set out in the plan of care is provided to resident # 006 as specified in the plan. [s. 6. (7)]

4. Inspector # 542 completed a health care record review for Resident # 005. It was noted that the Resident's care plan indicated specific interventions related to the fall prevention such as, ensure environment is free of clutter, wear proper and non-slip footwear, reinforce need to call for assistance and ensure that bed is in appropriate position to ensure resident's feet touch the floor. However, the kardex did not specify any interventions. The care plans for the Residents on this unit are located on the computer and the kardex was in a binder for the Health Care Aides to review. The Inspector interviewed several Health Care Aides, all of which stated that they do not have access to the care plans and that they only have access to the Kardex.

2. Inspector #594 observed Resident #012 with a chair alarm applied. Inspector #594 reviewed the care plan and identified the intervention of chair sensor be applied when the Resident was in the wheelchair. Review of the Kardex, which directs staff regarding resident care, did not identify the use of the chair sensor within the Kardex. This was confirmed by Staff # 136 and Staff # 137. Interview with Staff # 101, by Inspector #594, validated that the Kardex failed to identify application of the chair sensor and that direct care staff and others are not kept aware of the contents of the plan of care consistent with the needs of Resident #012.

The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Inspector # 544 reviewed Resident # 011 health care records, progress notes and care plan and identified that a wound would close and reopen several times over the last several months.
The wound continued to persist as identified in the progress notes and the weekly wound care assessments.

Staff # 117 and Staff # 148 confirmed that Resident # 011 has not had a consult with a wound care specialist or an outside agency in regards to this recurrent wound.
Staff # 148 stated that there could be other reasons as to why the wound continued to reopen and that the Physician had not examined Resident # 011's wound over this period of time.

The licensee failed to ensure that a resident exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relieve pain, promote healing and

prevent infection as required.

2. Resident # 016 had a wound. The Registered Staff have been monitoring the wound.
The interventions for the wound were monitoring by the wound care team weekly and turning and positioning the Resident q 2 hourly and the use of a therapeutic cushion.
It is written in the care plan regarding the wound that " once debrided, the stage should then be implemented."
To date, there was no direction as to when the wound would be debrided.
The wound was described by Registered Staff as, "continues to be boggy and the wound area was necrotic."
Inspector # 544 observed Resident # 016's wound to have opened and the wound was draining. Inspector # 544 reported this to Staff # 108 who was going to report this to Staff # 147 who was going to do the wound care at some point.

Resident # 016 complained of pain many times and expressed the intensity of the pain as being 10/10.
There was no focus, goals or interventions identified in regards to Resident # 016's pain.
Inspector # 544 reported Resident # 016's pain to the Staff # 108, who then administered the medical directive for pain medication to Resident # 016.

This was confirmed by Staff # 117 and on August 13, 2014, Staff # 117 revised the plan of care to reflect pain management and also initiated Wound Care Protocol (WCP).
A physician had not assessed Resident # 016's pressure wound during this month or assessed for pain management.

The licensee failed to ensure that a resident exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required. [s. 50. (2) (b) (ii)]

2. Resident # 016 had a wound. Inspector # 544 reviewed the weekly wound care assessments and found the documentation of the assessments to be incomplete.
There were no documented wound measurements noted on the weekly Wound Assessment Record for several weeks.
Staff # 117 confirmed that there were no wound measurements documented on the Wound Assessment Record for several weeks.

The home's Skin and Wound Care Program, Date issued July 31, 2008 and revised March 20, 2014 stated:
"Measuring Wound size will be done weekly and documented on the "Wound Assessment Record."

The licensee did not ensure that Resident # 016, exhibiting altered skin integrity, i.e. wound, had their wound measured weekly and documented on the "Wound Assessment Record, by a member of the registered nursing staff." [s. 50. (2) (b) (iv)]

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 to ensure that the skin and wound program provides strategies to promote resident comfort and mobility including the monitoring of residents and that residents exhibiting altered skin integrity receive immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in

the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

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 that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
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).

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).

Findings/Faits saillants :

1. Inspector # 544 reviewed a Critical Incident report.
Resident # 018 died suddenly in the home.
Inspector # 544 reviewed the health care records, progress notes and other relevant documentation for Resident # 018 and identified that the Coroner had ruled Resident # 018's death as accidental. This was confirmed by the death certificate that was completed by the Coroner.
The home did not report the unexpected death immediately to the Director as required.

This was also confirmed by Staff # 101.

The licensee did not ensure that the Director was immediately notified in as much detail as possible, of the unexpected and sudden death of Resident # 018, including the death resulting from an accident. [s. 107. (1)]

2. While reviewing Resident #021's health care records, Inspector #543 identified that Resident # 021 had a fall that resulted in a transfer to the hospital and a significant change in this Resident's condition. As a result of this finding, the Inspector spoke with Staff # 101 who confirmed that a Critical Incident report was not sent to the Director.

The licensee failed to ensure that the Director was informed of the incident that causes an injury to a resident for which the resident is taken to hospital and that results in significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

Inspector # 543 reviewed a Critical Incident report.
Inspector # 543 reviewed Resident # 022's health care records and identified that Resident #022 eloped from the home and went around the front of the building and entered another area within the home. The home was notified of this Resident's elopement by the staff from another area.

Inspector #543 reviewed the home's Policy-Responsive Behaviour: Elopement. This policy stated that the Home area program coordinator was to submit a Critical Incident within one business day following any incidents where the resident was missing. Inspector #543 identified that the home did not submit a a Critical Incident to the Director no later than one business day. This was confirmed by Staff # 101.

The licensee failed to ensure that the Director was informed of Resident #022's elopement no later than one business day after the occurrence of the incident. [s. 107. (3)]

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 to ensure that the Director is immediately informed in as much detail as possible in an unexpected or sudden death, including a death resulting from an accident and to ensure that the Director is informed no later than one business day when a Resident is missing for less than three (3) hours and who returns home with no injury or adverse change in condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. During the initial tour of the home and over the course of the inspection, the Inspectors observed infection control practices throughout the home. Inspector # 595 observed that in one of the Resident's shared bathrooms there were multiple unlabelled toothbrushes, and other personal care items. It was also observed that one toothbrush was on the toilet lid and was one centimeter away from a raised toilet seat stored on the wall.
Inspector # 542 observed a soiled peri wash bottle mixed in with other clean peri wash bottles located in one of the spa rooms.
Inspector # 597 also noted several personal care items unlabelled in a number of spa rooms, such as, nail clippers, combs, denture cups, and toothbrushes.
Inspector # 597 found unlabelled personal items in the following shared areas, Spa, shower areas throughout the home and unclean tubs in other home areas.

2. The Inspectors monitored several dining rooms during the meal times and noted poor hand hygiene practices among the staff when they were providing care and services to the Residents such as, serving Residents' meals, removing dirty plates from other Residents and positioning and repositioning Residents in their chairs. Staff were not washing their hands in between Residents. The Inspectors observed staff providing resident care to one Resident then proceeding to another Resident and not completing any hand hygiene. A Staff serving the Residents' meals, did not wash their hands after touching soiled plates then proceeded to serve the food.
Inspector # 543 observed a Staff perform hand hygiene at the onset of their tasks, but did not wash their hands in between tasks.

3. Inspector # 595 observed multiple toothbrushes, toothpaste, and personal items unlabelled in shared resident bathroom in other home areas.

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

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 to ensure that all staff participate in the implementation of the Infection Control Program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. Inspector #594 reviewed the home's policy titled: Linen and Resident's Personal Clothing, Date of Last Revision April 12, 2005, which fails to identify procedures as part of an organized program of laundry services. Inspector #594 interviewed Staff who validated a lack of program for laundry services to meet the personal clothing needs of residents.

The licensee has failed to ensure that there is an organized program of laundry services to meet the personal clothing needs of residents. [s. 15. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Inspector # 542 interviewed Resident # 005 and was informed that the home did not allow the Resident to stay up late at night. Resident # 005 identified that they would like to stay up a bit longer. Inspector # 542 conducted a health care record review and noted that the kardex and care plan did not identify the Resident's sleep patterns and preferences. Inspector spoke to Staff # 125 and Staff # 126 who confirmed that the Resident's sleep patterns and preferences should be located on the care plan and the kardex. Inspector was informed by Staff #149, that the home had updated Resident # 005's care plan and kardex to reflect the resident's sleep patterns and preferences.

The licensee failed to ensure that Resident # 005's plan of care was based on, at a minimum, an interdisciplinary assessment with respect to the resident's sleep patterns and preferences. [s. 26. (3) 21.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. Inspector # 597 reviewed Pioneer Manor - Resident Care Policies and Procedures Title: Personal Care Daily Grooming, Dressing, Foot and Nail Care, revised December 30th, 2012.
Under Section C - Oral Hygiene it is written:
1. "For residents with dentures, see policy concerning Denture Care." As confirmed by Staff # 101, this policy does not exist.
9. Dental Care Service Provider, see Resident Care "Dental Services." As confirmed by Staff # 101, this policy does not exist.

The licensee failed to provide a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. [s. 30. (1) 1.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. Inspector #594 observed Resident # 012 with a seat belt on when in the wheelchair. Inspector #594 reviewed the health care records for Resident # 012 and identified that it did not address restraint assessment. A review of the care plan and Kardex failed to identify the application of a seat belt. In an interview with Staff # 136, # 137 and # 117, they confirmed there was no documentation of a seat belt application in the care plan and Kardex. All three staff members identified the seat belt was a restraint. Staff # 101 stated that Resident #012 was unable to remove the seat belt and validated that no assessment had been completed and the care plan failed to address the seat belt.

Inspector #594 reviewed the home's policy titled Restraint Use (Least Restraint) date issued November 1992, Date of last revision: November 6, 2013 which stated the procedure for restraint use was to begin with a Resident assessment for use of a restraining device.

The licensee failed to assess the resident for this restraint and a plan of care was not developed for the use of the seat belt device which was currently being applied by the staff for Resident # 012.

The licensee failed to ensure that a resident may be restrained by a physical device if included in the residents' plan of care. [s. 31. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Inspector # 597 reviewed the home's Dental Care policy and identified that dental care was only discussed on admission. If the Residents chose not to enroll in Dental Care Program on admission, there was no evidence of a formal offer of dental care annually. This was also confirmed by Staff # 101.

The licensee failed to ensure that the resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident or the resident's substitute decision-make, if payment is required. [s. 34. (1) (c)]

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

Specifically failed to comply with the following:

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. Inspector # 542 reviewed a Critical Incident report.
Resident # 019 had a fall resulting in Resident # 019 being transferred to hospital and sustaining a fracture. Inspector # 542 reviewed the health care records for Resident # 019 and was unable to locate a post falls assessment for Resident # 019. Inspector interviewed Staff # 101 who confirmed that a post falls assessment, using a clinically appropriate assessment instrument specifically designed for falls, was not completed for Resident # 019.

The licensee has failed to 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. [s. 49. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Inspector # 597 interviewed Resident # 003 who identified that they were not happy with the change in continence product and that it did not meet their needs. According

to Resident # 003, they often have leakage through their brief and it was very uncomfortable and caused soreness.
Inspector # 597 interviewed Staff # 101 who confirmed that the Continence Care and Bowel Management Program was not evaluated annually.

The licensee failed to ensure that the continence care and bowel management program provides an annual evaluation of resident's satisfaction with the range of continence care products in consultation with residents, substitute decision makers and direct care staff with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. [s. 51. (1) 5.]

2. Resident # 003 told the Inspector that they do not like the "continence product" being used as they are loose and leak urine, which the Resident stated has caused soreness in their groin areas. The Staff told the Inspector that the Resident's night brief size is not available in the home for use. The care plan stated that the Resident did not wish to be woken up during the night for a brief change.

The licensee failed to ensure that the residents are provided with a range of continence care products that are appropriate for the time of day, and for the individual resident's type of incontinence. [s. 51. (2) (h) (i)]

3. Resident # 003 stated that they do not like the "continence product" being used at the present time as they are loose and leak urine, which they stated had caused soreness in the groin areas. According to staff, the Resident's size was not available in the home.

The licensee failed to ensure that the residents are provided with a range of continence care products that promote resident comfort, ease of use, dignity and good skin integrity. [s. 51. (2) (h) (iii)]

4. Inspector # 597 interviewed Resident # 003 and the Resident stated that they do not like the "continence products" being used as they were loose and leak urine, which has caused soreness in their groin areas. Resident # 003's size is not available as a night brief, as was stated by the Staff. According to staff, Resident # 003 is incontinent of large amounts of urine. Staff # 148 had asked the Program Coordinator to consider ordering night briefs in a larger size but they have not been ordered as yet. Night briefs are available in other sizes which do not fit Resident # 003.

The licensee failed to ensure that the residents are provided with a range of continence care products that are appropriate for the time of day, and for the individual resident's type of incontinence. [s. 51. (2) (h) (v)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. Inspector # 597 interviewed Staff # 103 who stated that Meal and Snack times were reviewed and approved by the the Food Committee. This was confirmed by the Food Committee Minutes. Inspector # 597 reviewed the Food Committee minutes and identified that the Meal and snack times were approved by the Food Committee. Meeting minutes were provided by Staff # 103 which reflected that Residents' Council approved that the snack and menu cycles be reviewed by the Food Committee. There are four regular attendees at the Food Committee Meetings. They are the home area representatives on the Residents' Council. These Residents are Resident # 023, # 024, # 025 and # 26.
Staff # 103 was not aware how the Food Committee updates are provided to the Residents' Council. Staff # 103 confirmed that Food Committee minutes were posted by the vending machines on the main floor.
Meeting minutes obtained from several Residents' Council meetings, do not reflect that the Food Committee meeting minutes are formally circulated or communicated to the Residents' Council members.

Inspector # 597 reviewed the Residents' Council Meeting Minutes and identified that no records or documentation could be found regarding the menu cycle being reviewed by the Residents' Council. The Residents' Council President stated menu cycle review was never discussed at Residents' Council meetings.

The licensee failed to ensure that the home's menu cycle is reviewed by the Residents' Council for the home. [s. 71. (1) (f)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector # 597 reviewed the minutes of the Residents' Council Meetings and could not find records that the meal and snack times were reviewed by the Residents' Council.
The Residents' Council President stated meal and snack times were not reviewed nor discussed at Residents' Council meetings.
The President also confirmed that discussions and decisions at the Food Committee meetings, are not communicated formally to the Residents' Council. The President stated that meal times are set 0800, 1200 and 1700 and have always been that way. Meal time hours had never come up for discussion. As well, snack times were not discussed.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the review of meal and snack times by the Residents' Council. [s. 73. (1) 2.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Resident #002 and #009 reported that personal clothing items were missing in the past two months, had been reported to staff and remained missing. An interview with Staff # 112 identified that the home had no formal communication regarding how missing clothing was communicated amongst staff and confirmed knowledge of some missing items. These missing items were not recorded and there was no formalized process for recording, searching and the resolving of missing laundry. Inspector #594 interviewed Staff # 118 who confirmed a lack of process to report and locate residents' lost clothing. Inspector #594 reviewed the home's policy titled: Linen and Resident's Personal Clothing, Date of Last Revision April 12, 2005, which failed to identify procedures to report and locate Residents' lost clothing.

The licensee has failed to ensure there is a process to report and locate residents' lost clothing and personal items. [s. 89. (1) (a) (iv)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Inspector # 544 interviewed Resident # 07, # 09, # 14 and #17, who all told Inspector that they had items such as a watch, craft supplies, necklace and a ring that were lost or went missing and never returned to them. Inspector # 544 could not find any documentation or record keeping in the home that dealt with the date and time a complaint was received in regards to missing articles or property, (excluding clothing), and the nature of each verbal complaint in regards to missing property. Documentation could not be found regarding the actions to be taken regarding a verbal complaint or how to resolve of the issues verbalized in regards to missing property.

Inspector # 544 interviewed Staff # 118 and Staff # 119, who confirmed, that there was no documentation or record kept of missing property or when personal property is found in the industrial washing machines nor how to handle this. Both Staff members confirmed that they are presently working on a new format for record keeping which will cover all aspects of the record keeping and resolve the missing property as well as incorporate missing laundry.

The licensee did not ensure that every written or verbal complaint made concerning the operations of the home in regards to missing property is dealt with and a documented record is kept. [s. 101. (2)]

Issued on this 3rd day of October, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANCA MCMILLAN (544), BEVERLEY GELLERT (597), JENNIFER LAURICELLA (542), MARINA MOFFATT (595), MONIKA GRAY (594), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2014_283544_0021
Log No. / Registre no:	S-000329-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 2, 2014
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TONY PARMAR

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_140158_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

1. Inspector # 597 reviewed the health care record (including the Resident's care plan, kardex and progress notes) for Resident # 003. The care plan identified that Resident # 003 had a device device in situ.
Inspector # 597 interviewed Resident # 003 and found no medical device in situ. Resident # 003 stated that the urinary device had been removed “sometime ago."
Staff # 122 and Staff # 135 confirmed that no medical device was in situ for Resident # 003.
The plan of care did not identify that this medical device had been removed.
Inspector # 597 observed that Resident # 003 did not have a medical device in situ.

The licensee has failed to ensure that there is a written plan of care for each

resident that sets out clear directions to staff and others who provide direct care to the resident.

2. Inspector # 544 reviewed the progress notes and wound assessment records for Resident # 016 and identified that Resident # 016 had a wound. The Registered Staff have been monitoring the wound.
There were no wound measurements documented for the weekly wound care assessments for several weeks.
The interventions for the wound were, "weekly monitoring of the wound by the wound care team, turning q 2 hourly and to use a therapeutic cushion.
The wound was described by Staff # 147, "assessment completed, continues to be boggy and the wound area was necrotic."
It is written in the care plan in regards to the wound to the wound, " once debrided, the stage should then be implemented."
To date, there was no direction as to when the wound would be debrided or staged.
Staff # 117 confirmed that the plan of care did not give clear direction to staff in regards to caring for this wound. Staff # 117 initiated Wound Care Protocol (WCP) and revised Resident # 016's plan of care.

3. Inspector # 544 observed Resident # 016's wound and found the wound to have an open area of skin and the wound was draining. Inspector # 544 reported this to Staff # 108, who was going to report this to Staff # 147. Staff # 147 was going to do the wound care at some point.

Resident # 016 complained of pain in their wound area to Inspector # 544 several times and expressed the intensity of the pain as being 10/10.
No focus, goals or interventions were identified in the plan of care in regards to Resident # 016's pain or pain management.
Inspector # 544 reported Resident # 016's pain to the Staff # 108, who then administered the medical directive for pain medication to Resident # 016.
This was confirmed by Staff # 117. Staff # 117 revised the plan of care to reflect pain management and also initiated Wound Care Protocol (WCP) for Resident # 016's wound.
Staff # 117 also instructed Staff # 108 to call the physician for other pain medication.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care

to the resident. (597)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 10, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Franca McMillan

Service Area Office /
Bureau régional de services : Sudbury Service Area Office