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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 16, 2017	2017_613609_0003	015759-16, 016547-16, 018514-16, 019874-16, 024779-16, 030940-16, 033733-16	Complaint

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

CHAD CAMPS (609), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 9-13 and January 16-19, 2017.

This inspection was conducted as a result of: One complaint submitted to the Director related to a resident's fall; and Six complaints submitted to the Director related to the care of residents.

A Critical Incident Inspection #2017_613609_0002 and a Follow Up Inspection #2017_613609_0001 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MRC), Manager of Administration, Manager of Physical Services (MPS), Program Coordinators (PCs), Intake Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Maintenance Workers, Health Care Aides (HCAs), Schedulers, residents and family of residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staffing schedules, staff training records, components of human resource files, internal investigations, policies, procedures, programs, and annual program evaluation records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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:
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. The licensee has failed to ensure that the resident participated fully in making any decisions concerning any aspect of their care, including any decision concerning their admission, discharge or transfer from a secure unit.

A complaint was submitted to the Director, alleging that the home had moved resident #001 from a secure unit to an unsecured unit without any discussion with the Substitute Decision Maker (SDM) or family. The complainant further indicated that "the home had made their decision and the resident was to be moved". The only decision given to the family was to which location in the home. The SDM had not been involved in the decision to move the resident out of the secured unit.

Inspector #627 reviewed resident #001's health care records and found in a progress note that on a particular day, Program Coordinator (PC) #107 documented that the resident's SDM was to be contacted by the intake department to review that the resident no longer required placement in a secure unit and would be transferred to an unsecured unit when a bed became available.

During an interview with the Intake Coordinator they stated that when a resident was assessed to be transferred from a secure unit to an unsecured unit, the PC would notify and advise the SDM/family of the type of room required. The Intake Coordinator stated that any concerns the SDM/family had, would have been discussed with the PC. The Intake Coordinator further stated that they had contacted resident #001's family to advise them of the transfer and to invite them to see the room the resident was going to be moved to. The resident was moved from the secured unit on a particular day.

During an interview with the Inspector, PC #107 stated that there should be a discussion with the SDM/family prior to moving a resident from a secured unit. PC #107 was unable to provide any documentation indicating that the family had been involved or participated in the decision to move the resident off the secured unit. PC #107 was unable to verify that any conversations had taken place with resident #001's family prior to the family being notified that the resident was being moved to an unsecured unit. [s. 3. (1) 11. iii.]

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 resident participates fully in making any decisions concerning any aspect of their care, including any decision concerning their admission, discharge or transfer from a secure unit, to be implemented voluntarily.

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The license has failed to ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Director, alleging that resident #005's SDM was not informed of a wound to the resident and subsequent treatment.

Inspector #627 reviewed resident #005's health care records and found that on a particular day altered skin integrity was identified.

A review of the home's internal investigation found that a wound was identified on resident #005 and that their SDM was not notified of the wound or its treatment.

During an interview with PC #107, they verified that the SDM had not participated in the development or implementation of resident #005's wound plan of care. [s. 6. (5)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols developed for the medication management system were implemented.

A complaint was submitted to the Director, alleging that residents were being left unattended with their medications and that medications had been found on the floor.

On a particular day, Inspector #627 observed breakfast in an identified dining room. The Inspector observed RPN #115 place medications in front of residents #010, #011, #012, #013, 014 and #015, instructing them to take their medications and then walked away before the residents had taken their medications.

The Inspector observed resident #012 with their medication in front of them for five minutes before the resident was removed from the dining room. Resident #012's medications were returned to the medication cart by RPN #115.

Resident #014 was observed taking some of their medication and discarding an unknown amount left over in their unfinished bowl of cereal. When the Inspector asked resident #014 why they had discarded part of their medication, the resident replied that they had had enough.

Resident #015 received their medications at 0855 hours. At 0920 hours a PSW walked by and reminded the resident #015 to take their medications and walked away. The resident proceeded to take their medications five minutes later.

A review of the home's policy titled "Medication Administration", last revised April 28, 2016, indicated that the resident was to be observed after administration of medications to ensure that the dose was completely taken.

During an interview with RPN #115 they stated that residents were to be observed taking their medications.

During an interview with PC #116 they stated that the registered staff dispensing medications was expected to administer and observe the residents taking their medications. [s. 114. (3) (a)]

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Issued on this 3rd day of April, 2017

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

Original report signed by the inspector.