Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 8, 2019	2019_786744_0020	007490-19, 010604-19	Complaint

Licensee/Titulaire de permis

City of Greater Sudbury
200 Brady Street 4th Floor SUDBURY ON P3E 3L9

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

STEVEN NACCARATO (744)

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): June 10-14, 2019

The following intakes were inspected on during this Complaint inspection:
-Two intakes related to resident care concerns.

Follow-up inspection #2019_786744_0019 and Critical Incident System inspection #2019_786744_0018 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director, Acting Manager of Resident Care (AMORC), Manager of Resident Care (MORC), Manager of Administration (MOA), Nutritional aide, Program Coordinators (PCs), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietitian (RD), Physician, Manager of Therapeutic Services (MOTS), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), family members and residents.

The Inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personnel records, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provisions of the care set out in the plan of care were documented.

A complaint was submitted to the Director, regarding concerns of resident #006 not being provided a specific care.

Inspector #744 reviewed resident #006's electronic care plan, which identified that specific care for the resident was to be provided at multiple times during the day shift.

The Inspector reviewed resident #006's Point of Care (POC) health care record and identified that from specified dates, the specific care was documented only once during day shifts.

Inspector #744 interviewed PSW #138 who stated that they provided the specific care to resident #006 multiple times during the day shift. PSW #138 further indicated that they believed that the specific care was only to be documented once per shift.

Inspector #744 interviewed PSW #142 who stated the specific care is normally done multiple times a day and that documenting after each time the specified care is provided is not always being done.

Inspector #744 reviewed the home's policy titled "Documentation Practices" revised June 17, 2016, which indicated that "All care/interventions are to be documented immediately after care given".

In an interview with Inspector #744, the AMORC stated that staff are required to document care that is provided. After reviewing resident #006's care record from the specified dates, the AMORC stated that the specific care for the resident is done regularly and staff will be reminded to document the care they provide to the resident. [s. 6. (9) 1.]

Issued on this 10th day of July, 2019

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

Original report signed by the inspector.