Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 16, 2020	2020_657681_0008	005011-20, 010115-20	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

STEPHANIE DONI (681), AMY GEAUVREAU (642), 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): July 6-10, 2020.

The following intakes were completed during this Complaint inspection:

- Two complaints submitted to the Director related to resident care concerns.

A Follow up inspection, #2020_657681_0006, and a Critical Incident inspection, #2020_657681_0007, were conducted concurrently with this inspection.

PLEASE NOTE - One intake was related to the same issue as was identified in a critical incident intake and was inspected on during this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MORC), Resident Care Coordinators (RCCs), Physicians, Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident records and policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (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 licensee 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 SDM 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 regarding errors in administering a medication.

During an interview with Inspector #627, resident #002's SDM stated that resident #002 was given a medication without their consent.

Inspector #627 reviewed resident #002's health care records, including a Physician's order for the specified medication. A subsequent Physician's order identified that the specified medication was discontinued approximately one month after it was initially ordered.

Inspector #627 reviewed the electronic medication administration record (eMAR) and noted that the specified medication was administered as per the Physician's order.

Inspector #627 reviewed the home's policy titled, "Physician Orders: Obtaining and Processing", last revised October 4, 2018, which indicated that "all residents/SDMs are to have an opportunity to be part of the decision-making process when changes are made to his/her medication or treatment plan.

Inspector #627 reviewed a progress note, created by RPN #124, which indicated that the SDM was made aware of the Physician order for the specified medication, but that the SDM did not want staff to administer the medication. Inspector #627 reviewed another progress note, created by RCC #102, which indicated that the SDM did not want the specified medication ordered and the RCC offered to send a referral to pharmacy for a medication review and to speak with the Physician.

Inspector #627 interviewed Physician #115 who stated that they had ordered the specified medication. Physician #115 stated that they were not aware that the SDM did not want resident #002 to be on the medication until one month after it was ordered.

Inspector #627 interviewed Pharmacist #117 who stated that they had received the order for resident #002's specified medication and that the order had not been put on hold.

Inspector #627 interviewed RPN #124 who stated that when a Physician ordered a new

medication, the SDM would be called and made aware. They further stated that if the SDM had not wanted the medication administered, they would document the conversation in Point Click Care (PCC), write the SDM's concern in the Nursing concern/MD's progress notes, and would put the medication on hold, by notifying the pharmacist and writing in the eMAR that the medication was on hold. Upon review of the progress notes, the Physician's order, and eMAR, the RPN acknowledged that they had not put the medication on hold and could not remember why they had not put the medication on hold.

Inspector #627 interviewed the Manager of Resident Care (MORC) who stated that if a SDM verbalized that they did not want a medication given to a resident, it should be put on hold until the Physician and the Pharmacist could speak to the resident and that a medication should not be given without consent. [s. 6. (5)]

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, 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, to be implemented voluntarily.

WN #2: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved, where possible, and a response that complied with paragraph 3 was provided within 10 business days of receipt of the complaint.

A complaint was submitted to the Director regarding care concerns, from staff towards resident #002.

During an interview with Inspector #627, resident #002's SDM, stated that they forwarded an email to RCC #102, in follow up to a conversation they had with RCC #102 the day prior. The complainant further stated that they had not received any follow-up in regards to this email.

Inspector #627 reviewed the email, which included concerns regarding the cleanliness of equipment and continence care. The email also included pictures associated with resident #002's concerns.

Inspector #627 reviewed the home’s policy titled “Complaints/Concerns and Reporting Requirements”, last revised May 13, 2019, which indicated that when a complaint was brought forth, staff were to “begin an investigation to determine the root cause of the complaint and resolve the issue”.

Inspector #627 interviewed RCC #102, who acknowledged they had missed some of the pictures that were attached to the email. The RCC stated that they thought they had dealt with the concern and had not opened all the pictures in the email. (627) [s. 101. (1) 1.]

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response is provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

A complaint was submitted to the Director, regarding care concerns related to resident #002.

During an interview with Inspector #627, resident #002's SDM, stated that they forwarded an email to RCC #102, in follow up to a conversation they had with the RCC the day prior. The complainant further stated that there were pictures associated with their concerns attached to the email.

Inspector reviewed the home's policy titled "Complaints/Concerns and Reporting Requirements" last revised May 13, 2019, which indicated that "all written complaints concerning the care of a resident or the operation of the home will be forwarded immediately to the Centralized Intake and Assessment triage Team (CIATT) at [Ministry of Health and Long-Term Care] (MOHLTC) by email".

Inspector #627 interviewed RCC #102 who stated that they had spoken with the complainant, went to the resident’s room to address the concerns, and had requested that the complainant forward them an email with their concern.

Inspector #627 interviewed the Manager of Resident Care (MORC), who stated that it was the home’s policy to forward all written complaints to the Ministry of Long-Term Care. [s. 22. (1)]

Issued on this 27th day of July, 2020

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

Original report signed by the inspector.