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
Apr 14, 2021	2021_864627_0005	002357-21, 002379-21	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

SYLVIE BYRNES (627), AMY GEAUVREAU (642)

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): March 8-12, and 15-16, 2021.

The following intakes were inspected during this Complaint inspection:

- One log related to resident care concern, allegation of abuse and neglect; and,
- One log related to resident care concern and staff's use of personal protective equipment.

A Follow up inspection, #2021_864627_0004, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MORC), Physicians, Resident Care Coordinators (RCCs), Acting Resident Care Coordinator (ARCC), Infection Prevention and Control (IPAC) Lead, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), Rehabilitation Assistant (RA), Housekeeping staff, (HK), residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident's SDM stated that they had not been notified of two new medication orders, prior to the resident being administered the medications.

A review of the Physician's orders revealed the two orders prescribed by the Physician. A review of the electronic medication administration record indicated that the resident had received the medications 11 times prior to the SDM being made aware of the new medications.

Two RPNs stated that they had not called the SDM to make them aware of the resident's two new medicaitons.

The Manager of Resident Care (MORC) acknowledged that the SDM had not been called and notified of the new orders.

Sources: Interview with a resident's SDM, RPNs , MORC, record review eMAR,

Physican’s orders, progress notes, eMAR for the resident, home’s policy titled “Physician’s Orders: Obtaining and Processing". [s. 6. (5)]

2. The licensee has failed to ensure the resident’s plan of care was reviewed and revised when the resident’s care needs changed.

A complaint was submitted by a resident’s SDM regarding a specific care concern.

A review of the resident’s progress notes identified that the resident had an intervention in place for seven months, when it was discontinued.

A review of the resident’s care plan identified that the intervention was added to the resident's care plan close to three months after the intervention had been implemented.

A RPN acknowledged that they had not added the intervention to the resident's care plan for almost three months after the intervention was implemented.

The Manager of Resident Care (MORC) stated that the intervention should have been added to the care plan when the intervention was implemented.

Sources: Interviews with the complainant, an RPN, MORC and other staff members; a resident’s care plans, progress notes, bedside assessment tool and the home's policy titled "Documentation Resident Care Plan".

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 is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policies in the continence care bowel management program were complied with.

Ontario Regulations (O. Reg.) 79/10, section (s.) 48 (1) (3) requires a continence care bowel management program to promote continence and ensure that residents are dry and comfortable.

O. Reg. 79/10, s. 51. (2) (a) requires that that each resident who is incontinent receives an assessment that includes identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, and that the assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Specifically, staff did not comply with the home’s policy and procedure, “Continence Care and Bowel Management Program”.

The home’s continence care and bowel management policy identified that residents were to be assessed for bladder and bowel continence on admission, quarterly and when there was a change in their status that may affect continence. The bladder and bowel assessments would be completed in Point Click Care (PCC).

The Inspector reviewed three residents' most recent bladder and bowel assessments completed in PCC and identified that the last bladder and bowel continence assessment for all three residents was completed nearly a year ago.

The MORC acknowledged that the assessments were not completed in PCC in nearly a year for the three residents.

Sources: Interview with the complainant; "Continence Care and Bowel Management Program"; Bladder and Bowel assessments; Interview with the Manager of Resident Care, an RPN, and other staff members. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a RPN administered drugs to a resident in accordance with the directions for use specified by the prescriber.

A resident's enacted SDM brought forth concerns related to a resident's condition. The SDM stated that they had been made aware at that time, by an RPN in the home, that the resident was receiving medication as required for a specific symptom.

A review of the resident's Physician’s orders revealed an order for the medication to be given as required for a specific symptom.

A review of the electronic medication administration record indicated that the resident received the medications on two separate occasions. Two progress notes, referring to the medication administration, indicated that the medication had been administered for another purpose other than the symptom identified by the prescriber.

During an interview with the Inspector, an RPN stated that the resident exhibited a specific symptom daily; therefore, they had tried to avoid the symptom by administering the medication pre-emptively to avoid the resident developing the specific symptom.

In an interview with the Physician, they stated that giving medication when the resident was not exhibiting a specific symptom was not acceptable. It should have been administered only when the resident exhibited the symptoms.

Sources: Interviews with the resident 's SDM, an RPN, a Physician, MORC, record review, electronic medication administration records, , progress notes for the resident, and home’s policy titled “Medication Administration”. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program, related to hand hygiene.

The licensee's IPAC program required staff to ensure that residents were encouraged to wash their hands before eating and drinking. During observations of two dining services, the Inspector observed that residents were not assisted with performing hand hygiene prior to being served their meal. A Health Care Aide stated that the home had provided wipes to clean the resident's hands previously; however, they had not been replaced when they ran out.

The IPAC Lead acknowledged that the home's IPAC policy regarding hand hygiene should have been implemented and residents should have been assisted with hand hygiene before and after their meal.

Sources: Observations on a unit and dining room, interviews with Infection Prevention and Control Program Lead, HCA , and other staff; the home's policy, "Hand Hygiene Program" and "Just Clean Your Hands" program resources. [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 program, to be implemented voluntarily.

WN #5: 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 had failed to ensure that a resident's SDM was provided with a response within 10 business days of the receipt of a complaint.

A resident's SDM stated that they were provided with a response to a written complaint they had submitted to the home, 20 days after they had submitted the complaint.

The MORC acknowledged that a response was provided to the complainant 20 days after it was submitted to the home.

Sources: Interview with a resident’s SDM, MORC, record review, complaint letter, response letter to the complaint, home’s policy titled, “Complaints/Concerns and Reporting Requirements”. [s. 101. (1) 1.]

Issued on this 20th day of April, 2021

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

Original report signed by the inspector.