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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 21, 2021 | 2021_906687_0005 | 012717-21, 012843-21 | 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

LOVIRIZA CALUZA (687)

## 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): September 13-16 and September 20-24, 2021.**

**The following intakes were inspected on during this inspection:**
**- Two intakes regarding alleged abuse, personal care not provided, staffing and medication administration, Infection Prevention and Control (IPAC) protocols, continence care, nutrition, sleep and wake times and plan of care.**

**During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care (MORC), Resident Care Coordinator (RCC), IPAC Lead, Manager of Therapeutic Services, Acting Manager of Physical Services, Food Service Supervisor (FSS), Coordinator of Volunteerism & Recruitment, Physician, Registered Dietitians (RDs), Registered Nurses (RNs) Registered Practical Nurses (RPNs), Physiotherapist, Occupational Therapist, Accounts Administrator, Nutritional Aides (NAs), Personal Support Workers (PSWs), Behaviour Support Officer (BSO) - PSW; Housekeepers, Staff Schedulers, COVID 19 Screeners, residents and family members.**

**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, observed staff and residents Infection Prevention and Control (IPAC) practices, reviewed resident's health records, reviewed the Best Practices for Hand Hygiene in All Care Settings, 4th Edition from the Provincial Infectious Diseases Advisory Committee (PIDAC), reviewed the Directive #3 and the Ministry of Long-Term Care Homes (MLTCH) COVID-19 Guidance Document for LTCHs dated June 9, 2021, reviewed the staffing schedules, internal investigations and the home's policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Dining Observation**
**Infection Prevention and Control**
**Medication**
**Personal Support Services**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Snack Observation**
**Sufficient Staffing**

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

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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 a resident's enacted substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A documentation note indicated that a staff member had reported that a resident had altered skin integrity of unknown origin.

The staff member had reported this incident to a registered staff. The registered staff had documented this but did not notify the enacted SDM. The Resident Care Coordinator (RCC) stated that registered staff were to notify the family of any skin integrity concern unless indicated otherwise.

Sources: A complaint submitted to the Director, resident and staff observations, review of the resident's health care records, the home's policy titled "Documentation: Resident Care Plan", interview with the resident, enacted SDM, the RCC and other staff members. [s. 6. (5)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care of the resident was documented.

Three (3) separate observations were conducted regarding continence care of a resident.

Health care records indicated that the resident would be assisted with their continence

care routine and staff members were to complete the documentation.

Staff members were interviewed and acknowledged that they had documented the continence care of the resident whenever they had time. The RCC stated that the resident's continence care was to be documented as soon as it was completed.

Sources: A complaint submitted to the Director, observations, resident's health care record reviews, the home's policy titled "Documentation, Resident Care Plan", and interviews with the enacted SDM, the RCC and other staff members.

2) Another resident's health care record indicated that they would be assisted with their continence care routine and staff members were to complete the documentation.

The continence care documentation record indicated that staff members had documented the continence care of the resident inaccurately.

The RCC reviewed the documentation of the resident's continence care routine and acknowledged that the staff members had documented it inaccurately.

Sources: Review of a resident's health care records and interview with the RCC.

3) A subsequent review of another resident's health care record indicated that they would be assisted with their continence care routine and staff members were to complete the documentation.

The continence care documentation record indicated that staff members had documented the continence care of the resident inaccurately.

The RCC reviewed the documentation of the resident's continence care routine and acknowledged that the staff members had documented it inaccurately.

Sources: Review of a resident's health care records and interview with the RCC. [. 6. (9) 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 a resident's enacted substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, and to ensure that the provision of the care set out in the plan of care of the resident is documented, to be implemented voluntarily.***

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**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 home's policy titled "Restorative Care Programs" was complied with.

O. Reg. 79/10, s 53 (4) c required actions that were taken to respond to the needs of the resident, including assessments and interventions.

Specifically, the staff did not comply with the home's policy titled "Restorative Care Programs".

Resident's health care record indicated that the resident was repeatedly observed with an action that required continuous reminder to prevent altered skin integrity concerns.

The staff member acknowledged that the resident was at risk of altered skin integrity concerns and a referral was supposed to be completed due to this repeated action. The Manager of Therapeutic Services verified no referrals received at that time.

SOURCES: A complaint was submitted to the Director, resident and staff observations, resident's health care record reviews, the home's policy titled "Restorative Care Programs", interview with the Manager of Therapeutic Services, the resident 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 home's policy titled "Restorative Care Programs" is complied with, to be implemented voluntarily.***

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**WN #3: 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. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident who was unable to manage their continence care independently received assistance from staff to manage and maintain their continence.

Three (3) separate observations were conducted regarding the continence care routine of a resident and identified that the routine was not being followed.

Health care records indicated that the resident would be assisted with their continence care routine by staff members.

A staff member and the RCC stated that the resident had a continence care routine and the staff members were expected to follow this routine as stated in the resident's care plan.

Sources: A complaint was submitted to the Director, resident and staff observations, resident's health care records review , the home’s policy titled “Continence Care and Bowel Management”, interview the RCC and other staff members. [s. 51. (2) (c)]

***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 a resident who is unable to manage their continence care independently receive assistance from staff to manage and maintain their continence, to be implemented voluntarily.***

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**WN #4: 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: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home provided the resident with personal assistance and encouragement to eat as comfortably and independently as possible.

A snack observation was conducted and identified a resident's snack was left on a nearby piece of furniture. There was no staff observed to provide personal assistance to the resident at that time.

A number of unopened snacks for the resident was identified.The Registered Dietitians (RDs) stated that the resident would require assistance for the snack service from staff members as stated in their care plan.

Sources: A complaint submitted to the Director, observation of the resident and staff members, the home's policy titled "Nutritional Services – Snacks", resident's health care record reviews, interview with the enacted SDM, the RDs and other staff members. [s. 73. (1) 9.]

***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 home provide the resident with personal assistance and encouragement to eat as comfortably and independently as possible, to be implemented voluntarily.***

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**WN #5: 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 members would offer residents hand hygiene before and after meal service and access to hand wipes.

Multiple observations were conducted in the DRs. It was identified that residents were not being offered hand hygiene before and after a meal service and that the hand wipe dispensers were not dispensing properly which prevented access to staff members and residents.

Residents stated hand hygiene was important to them but had not been offered by staff members before and after a meal service.

A staff member stated that they were uncertain who would offer hand hygiene to residents before and after a meal service in the DR and that the hand wipe dispenser was not dispensing properly. The (Infection Prevention and Control) IPAC Lead stated that hand hygiene before and after meals and availability of hand wipes to residents and staff members were important to prevent potential transmission of infection in a congregated setting like the DR.

Sources: A complaint submitted to the Director, observations of residents and staff, the

home’s policy titled “ Infection Control: Outbreak Detection and Management of COVID -19”, Best Practices for Hand Hygiene in All Care Settings, 4th Edition from the Provincial Infectious Diseases Advisory Committee (PIDAC), interview with the IPAC Lead, residents and other staff members.

2) The licensee has failed to ensure that residents and visitors participated in the implementation of universal masking program.

In two separate observations, it was identified that staff members and a visitor were not wearing their mask appropriately.

Directive #3 from the Ministry of Long Term-Care (MLTC) COVID-19 Guidance Document and the home's policy titled "Infection Control: Outbreak Detection and Management of COVID -19", indicated that "All staff and visitors must always comply with universal masking and must wear a medical mask for the entire duration of their shift/visit".

The Manager of Resident Care (MORC) stated that “All people entering the home were to wear a mask at all times". Inappropriate use of a mask would increase the risk of residents health and safety, staff members and anybody that would visit the home.

Sources: A complaint submitted to the Director, observations of staff, residents and visitors, Directive #3 and MLTC COVID-19 Guidance Document, and the home's policy titled "Infection Control: Outbreak Detection and Management of COVID - 19", interviews with the MORC, visitors and other staff members.

3) The licensee has failed to ensure that staff members participated in the implementation of additional precautions for isolation.

Isolation signage was posted at the entrance door of two residents. Two staff members were observed providing personal care to both residents with no Personal Protective Equipment (PPE) at that time.

The staff members stated that they were aware of the isolation signage but uncertain of who had the infection, therefore, did not wear any PPE.

The IPAC Lead and a staff member stated that the resident was on isolation due to an infection. Appropriate use of PPE as indicated on the signage when providing personal

care was recommended as they were high risk to transmit the infection to others.

Sources: Resident and staff members' observation, review of residents' health care records, the home's policy titled "Infection Control: Outbreak Detection and Management of COVID 19", interview the IPAC Lead and other staff members. [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 staff members offer residents hand hygiene before and after meal service and access to hand wipes; to ensure that staff members and visitors participates in the implementation of universal masking program, and to ensure that staff members participates in the implementation of additional precautions for isolation, to be implemented voluntarily.***

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**WN #6: 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. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1.The licensee has failed to ensure that the resident’s mobility equipment was kept clean and sanitary.

Multiple dried food was noted on the resident’s mobility equipment.

The equipment cleaning list indicated that the resident’s mobility equipment was listed but the staff had not completed and signed the cleaning list document monthly.

Staff members stated that they were to maintain the residents’ cleanliness of the mobility equipment monthly and spot clean when spillage of food was noted.

Sources: A complaint submitted to the Director, observation of resident’s mobility equipment, review of resident’s health care records, the home’s policy titled “Cleaning Responsibilities”, interview with the Manager of Therapeutic Services and other staff members. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Three observations were conducted in the DR areas and identified that the DR feeding stools were in a state of disrepair.

The Acting Manager of Food Services and staff members stated that they were aware of the DR feeding stools in disrepair and they were in process to replace them. They recognized that this would prevent proper equipment disinfection and risk for potential mode of infection.

Sources: A complaint submitted to the Director, DR observations, interviews with staff members, and the home’s policy titled “Preventative Maintenance”. [s. 15. (2) (c)]

**Issued on this 25th day of October, 2021**

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

**Original report signed by the inspector.**