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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 11, 2012	2012_138151_0017	S-000567-12,1272	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

MONIQUE BERGER (151)

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): November 27,28,29,30, 2012

This report relates to inspections done in regards to the following logs:
1- S-000567-12 related to IL-22878-SU
2- S-001272-12 related to IL-25379-SU

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care, Program Coordinators, Registered Staff, Personal Support Workers (PSW), Dietary Aide, Residents and Family members.

During the course of the inspection, the inspector(s) - made direct observations of the delivery of care and services to residents.
- did daily walk-through of the home
- reviewed resident health care records
- reviewed policies and procedures related to complaints made,
- reviewed the home's staffing plan and related contingency plan,
- reviewed the homes policies and procedures in relation to medication administration,
- audited staffing schedules

The following Inspection Protocols were used during this inspection:
Personal Support Services

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 not ensured that the resident, the resident's 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 in the plan of care. [LTCA,2007 S.O.2007,c.8, s.6.(5)]

Complainant alleges the home did not notify the complainant nor give the opportunity to consent when the resident was ordered and given a medication meant to sedate the resident. Review of the resident's health care record shows no notation that the family was notified in regards to the new treatment. On November 30, 2012, in response to a direct question asked by Inspector, three of five registered staff stated that they do not always notify the resident's substitute decision-maker when there is a change or an addition to the resident's medication regime.

] [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. 31. Nursing and personal support services

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Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has not ensured that they have provided a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation. [O.Reg.79/10,s.31.(3)]

On November 30, 2012, Inspector conducted an audit in regards to the provision of two baths per week. It was found that when the units worked short by at least one staff person, regular baths were preempted and bed baths substituted. On two (2) of the six (6) units, Inspector found notations on the resident's flow sheets that indicated that the unit worked short and the resident received no bath. For these residents, there is no further notation that indicates that another bath was substituted on that day or any following shift. In addition, three (3)of the twenty-eight (28) resident records audited showed gaps in recorded baths for 6 days or greater.

Two of three residents interviewed in regards to their baths confirmed that they have experienced missed baths because the unit was short staffed. Both of these residents stated that no other type of bath were substituted and make-up baths were not offered on subsequent shifts. These residents stated their next bath did not occur until the subsequent official bath day.

Inspector spoke to a staff member on each of the six (6)units audited. Staff on four of the six units stated that they did their best to bathe all residents, but they have had to substitute bed baths for their regular tub or shower baths when the unit is working short of a staff person. They stated that, on rare occasion, a bath could be missed.

Staff on two (2) fo the six (6)units audited stated that it was a "physical impossibility" to do any baths when their units were working short. Staff on these 2 units stated that they were not able to add extra baths to other shifts to "make up" for the missed baths. [s. 31. (3)]

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 the provision of a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has not ensured that food or fluids in the food production system are prepared, stored, and served using methods that prevent adulteration, contamination and food borne illness.[O.Reg.79/10, s.72.(3)(b)

On November 29, 2012, during the serving of food to residents, Inspector observed a breech in infection control practice. [s. 72. (3) (b)]

Issued on this 11th day of December, 2012

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

Monique G. Berger