Ontario

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

# Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

| Dates of inspection/Date de l'inspection | Inspection No/ d'inspection | Type of Inspection/Genre d'inspection |
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| December 14th, 15th 2010 | 2010_188_9566_14Dec093523 | Mandatory Report<br>Log #-S-00679, CI-M566-000027-10<br>CI-M566-000026-10<br>CI-M566-000029-10 |

**Licensee/Titulaire**
The City of Greater Sudbury, 200 Brady Street, PO Box 5000 Station A, Sudbury, ON, P3A 5P3. F 705-524-1767

**Long-Term Care Home/Foyer de soins de longue durée**
Pioneer Manor 960 Notre Dame Ave, Sudbury, ON P3A 2T4, F 705-524-1767

**Name of Inspector/Nom de l'inspecteur**
Melissa Chisholm 188

## Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a mandatory report inspection.

During the course of the inspection, the inspector spoke with: the Manager of Resident Care, Manger of Dietary Services, Manger of Therapeutic Services, 2 Registered Nursing staff, 5 Personal Support Workers, 1 Physiotherapy Assistant, 1 Activation Aid

During the course of the inspection, the inspector: Conducted a walk-through of all resident home areas and various common areas, observed the resident named in the mandatory report, observed staff practices and interactions with residents, and reviewed the health care record of the resident named in the mandatory report.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Critical Incident Response

Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire
**DR** – Director Referral/Régisseur envoyé
**CO** – Compliance Order/Ordres de conformité
**WAO** – Work and Activity Order/Ordres: travaux et activités

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| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**WN #1:** The Licensee has failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 6(1)c Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

**Findings:**

1. The inspector reviewed the clinical record of a resident. Six documented incidents of responsive behaviours were noted in the progress notes. The plan of care does not identify the resident's responsive behaviour. The licensee failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident in relation to the resident's behaviours.

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**WN #2:** The Licensee has failed to comply with LTCHA 2007 S.O. 2007, c.8, s.6(8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

**Findings:**

1. The inspector reviewed the clinical record of a resident. Six documented incidents of responsive behaviours were noted in the progress notes. The resident's care plan found in the binder labeled Health Care Aid Book did not include the responsive behaviours. The electronic version of the care plan did include the responsive behaviours however PSWs do not have access to the electronic version of the care plan. The licensee failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

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**WN #3:** The Licensee has failed to comply with O.Reg 79/10, s.53(1)1 Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

**Findings:**

1. Six documented incidents of responsive behaviours were noted in a resident's progress notes. However, the resident's plan of care has no screening, assessment, reassessment or identification of behavioural triggers noted as conducted in relation the resident's responsive behaviours. The licensee failed to develop written approaches to care including screening protocols, assessment, reassessment

and identification of the behavioural triggers that related to the resident's responsive behaviours.

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**WN #4:** The Licensee has failed to comply with O.Reg 79/10, s.53(1)2 Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

**Findings:**

1. The inspector reviewed the clinical record of a resident. Six documented incidents of responsive behaviours were located in the progress notes. No written strategies, including techniques and interventions have been developed in relation to the resident's responsive behaviour. The licensee failed to develop written strategies, including techniques and interventions, to prevent, minimize or respond to the resident's behaviour.

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**WN #5:** The Licensee has failed to comply with O.Reg 79/10, s.53(1)4 Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 4. Protocols for the referral of residents to specialized resources where required.

**Findings:**

1. The inspector reviewed the plan of care for a resident. Six documented incidents of responsive behaviours were located in the progress notes. No referrals were noted to any specialized resources in relation to the resident's behaviours. The licensee failed to develop protocols for the referral of residents to specialized resources where required.

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**WN #6:** The Licensee has failed to comply with O.Reg. 79/10, s.107(3)4 The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An injury in respect of which a person is taken to hospital.

**Findings:**

1. An incident occurred on October 17, 2010 at 0500h. The resident sustained an injury and was transferred to hospital. This incident was first reported to the ministry via telephone on October 26, 2010. It was reported via the Critical Incident System on October 29, 2010 at 1756h. This is not in accordance with the required time frame of one business day after the occurrence.

2. An incident occurred on December 1, 2010 at 2130h. The resident sustained an injury and was transferred to hospital. This incident was first reported to the ministry via the Critical Incident System on December 10, 2010 at 1849h. This is not in accordance with the required time frame of one business day after the occurrence.

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| **Signature of Licensee or Representative of Licensee**<br>**Signature du Titulaire du représentant désigné** | **Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** |
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| Title: | Date: | Date of Report: (if different from date(s) of inspection). |
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| | | January 24, 2011 |