



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

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

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.

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.

Inspector ID #: 188

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.

Inspector ID #: 188

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.

Inspector ID #: 188

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.

Inspector ID #: 188

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.

Inspector ID #: 188

Signature of Licensee or Representative of Licensee
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.





**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

**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***

Title:	Date:	Date of Report: (if different from date(s) of inspection). <i>January 24, 2011</i>
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