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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2015	2015_282543_0018	005112-14	Critical Incident System

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

TIFFANY BOUCHER (543), SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 24-28, 2015

The following logs were inspected:
004365-14, 005112-14, 005673-14, 006254-15, 006487-15, 006540-15, 007479-15, 018919-15, 023038-15 (S-000179-13).

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas. The inspectors reviewed resident health care records, and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Coordinators, Registered staff and Health Care Aides

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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	Legendé 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that caused an injury to resident #012 that resulted in a significant change in resident #012's health condition and for which resident #012 was taken to the hospital.

On August 25, 2015, Inspector #603 reviewed a critical incident report (CI) regarding an incident which occurred and was reported to the Director. The CI report indicated that resident #012 sustained a fall. Resident #012 informed the attending staff that they did not hit their head. According to the CI report, post fall, the resident was alert and oriented to time and place; the resident was assessed and sustained injuries. No other injuries were noted. The resident was then assisted back to bed by two staff members and the head injury routine was initiated.

Inspector reviewed resident #012's health care record and noted that the resident was able to get up and walk but remained in bed other than for meals. Following the incident,

resident #012 was complaining of pain and started to refuse their meals. They continued to be able to get out of bed and go to washroom and dining room. Two days after the incident, the resident started exhibiting responsive behaviors and was refusing to get out of bed and was not eating well. On the third day, resident #012 continued to have pain, remained in bed all day, but did get up to the washroom with the assistance of their walker and one staff member. At that time, concerns were brought to the physician and orders were received to send the resident to the hospital for further investigation. The resident was sent to the hospital. Resident #012 returned to the home on the same day, and the emergency nurse verbally informed staff that no serious injuries were noted.

Six days following the incident, resident #012's family requested the resident to return to the hospital for investigation relating to their pain. While preparing to transfer the resident to ER, the home's staff member found a report, showing the resident had a serious injury. The resident went to the hospital and returned to the home on the same day. Upon their return, the resident's family confirmed that the resident had a serious injury.

The resident developed respiratory issues and was sent to hospital for further investigations. The resident received treatment and 10 days later they passed away. The coroner reviewed the resident's cause of death.

On August 25, 2015, Inspector reviewed the home's policy titled: Documentation: Report of Critical Incidents, last revision: March 31, 2014, and the procedure #2 indicated: A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall within one (1) business day report the information upon which it is based to the MOHLTC Director: An injury in respect of which a person is taken to hospital and that resulted in a significant change in the resident's health condition. The term "significant change" is defined as "a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition, and requires and assessment by the interdisciplinary team or a revision to the resident's plan of care.

The incident was not reported to the Director until 13 days following the incident. According to the Long-Term Care Homes Act, 2007; Ontario Regulation the Director will be informed no later than one business day after the occurrence of an incident that causes an injury to a resident for which a resident is taken to the hospital. [s. 107. (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 that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident for which a resident is taken to the hospital., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #005 was treated with courtesy and respect and in a way that fully recognized and respected the resident's dignity.

A critical incident was reviewed whereby several allegations were brought forth regarding inappropriate actions by #S-104, which included inappropriate physical and verbal actions when providing care to the resident. #S-105 confirmed that they have heard #S-104 being verbally inappropriate when providing care to resident #005.

Inspector #543 spoke with #S- 100 who stated they spoke with #S-104 who admitted to behaving inappropriately towards the resident.

The home conducted an investigation, whereby the allegations were substantiated and #S-104 was disciplined. [s. 3. (1) 1.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Abuse: Resident Abuse/Neglect policy was complied with.

In a critical incident reported, allegations of abuse were brought forth whereby #S-106 provided inadequate care and exhibited inappropriate behaviour towards residents. The home conducted an investigation related to staff to resident abuse by #S-106, whereby #S-101 spoke with several residents who stated they felt emotionally abused by #S-106. One of the residents stated that they felt that #S-106 often ignored their requests and did not provide adequate personal care. Another resident stated that #S-106 refused to provide them a beverage and informed the resident to wait for the nourishment cart. Another resident stated that #S-106's attitude is often "bad", and that they felt that #S-106 got annoyed with them when they asked to have their soiled brief changed. According to the Long-Term Care Homes Act, 2007; Ontario Regulation any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, constitutes emotional abuse.

Inspector #543 spoke to #S-101 who stated that when they spoke with residents throughout the home's investigation these residents confirmed that #S-106's attitude was rude and at times #S-106 was visibly annoyed at having to provide care to residents. The inspector spoke with #S-101 specifically related to previous allegations of abuse by #S-106. #S-101 stated that past allegations were unsubstantiated. The investigation conducted by the home revealed that allegations brought forth were well founded.

Multiple concerns were reported by staff members related to #S-106 not providing

adequate care to residents that included but was not limited to, not answering call bells, failing to assist with feeding residents and not providing care as per the residents' care plans.

Inspector #543 reviewed the home’s Abuse: Resident Abuse/Neglect policy. This policy stated that residents will be free from abuse by staff, volunteers, service provider, visitors and other residents and that each resident has the right to complain and be assured of a full, equitable investigation in the event of resident abuse or neglect. This policy described that all employees, volunteers, students and service providers are expected to respond to residents with patience and compassion. [s. 20. (1)]

2. The licensee has failed to ensure that the home's Abuse: Resident Abuse/Neglect policy was complied with.

In a critical incident reported, #S-107 was verbally inappropriate and abusive towards resident #004. Documentation provided to the inspector from the home's investigation revealed that two staff members were transferring resident #004, whereby #S-107 became impatient and started raising their voice towards the resident. Inspector #543 reviewed documentation related to the alleged incident of abuse. This letter described that #S-107 was reported to have been verbally inappropriate with the use of profanity towards a resident #004. The letter described that #S-107 rushed the resident and forcefully provided care.

Documentation revealed that #S-101 spoke with the resident's family who were able to substantiate that #S-107 was verbally inappropriate towards resident #004. The home's investigation of the critical incident revealed that the approach and or actions of #S-107 constituted resident emotional/verbal abuse.

Inspector #543 reviewed the home’s Abuse: Resident Abuse/Neglect policy. This policy stated that residents will be free from abuse by staff, volunteers, service provider, visitors and other residents and that each resident has the right to complain and be assured of a full, equitable investigation in the event of resident abuse or neglect. This policy described that all employees, volunteers, students and service providers are expected to respond to residents with patience and compassion. The policy stated that resident abuse is among the gravest offenses and that residents must be treated with respect and dignity; and that the home is committed to providing competent and compassionate staff and volunteers for its residents.

According to the Long-Term Care Homes Act, 2007; Ontario Regulation any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident, constitutes emotional abuse. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse or neglect of a resident by the staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

An allegation of staff to resident abuse was brought forth to #S-100 and #S-103, whereby resident #008 reported that #S-108 was verbally abusive towards them which caused them distress. An investigation was initiated by the home and the allegations were unsubstantiated. Documentation provided to the inspector related to the home's investigation revealed that #S-108 was reassigned to another home area and was instructed to review the home's Abuse: Resident Abuse/Neglect policy.

This incident was not reported to the Director until six days after becoming aware of the alleged abuse. Inspector #543 spoke with #S-100 who confirmed that the critical incident was submitted late. [s. 24. (1)]

Issued on this 3rd day of November, 2015

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

Original report signed by the inspector.