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
Direction de l'amélioration de la performance et de la conformité

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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
Feb 11, 2016	2016_336620_0004	032422-15, 031034-15, 031621-15, 031762-15, 027496-15, 000581-16	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

ALAIN PLANTE (620)

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): January 14, 15, 18, 19, 20, 2016.

The inspector reviewed residents' health records, various policies, procedures, programs, employee records, and a number of the home's investigation documents. The Inspector also observed the delivery of resident care, and staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with residents, residents' Substitute Decision Makers (SDM), the Administrator, a Manager of Resident Care (MRC), a Program Coordinator (PC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and a Housekeeper.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that the licensee knew of, or that was reported to the licensee, was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of neglect that occurred on a specific date and was reported to the Director three days following the occurrence.

The CI described an incident involving a resident. The resident reported that staff member #108 attempted to wash their face with a soiled cloth. This occurred the same day that the resident had reported an incident of neglect; whereby, the resident was required to wait in excess of an hour to receive the care they required.

A review of the home's investigation revealed that the resident reported not receiving the care they required from staff member #107. The home's investigation documents further revealed that the resident reported that they made numerous attempts to have staff provide them assistance. Furthermore, the resident reported that they waited in excess of an hour and was in pain due to the extended wait.

Inspector #620 interviewed the resident. The resident stated that no staff member of the home had advised them of the outcome of their initial complaint of not receiving the care they required for in excess of an hour. The resident also stated that no staff member assessed their concerns of being in pain following the incident.

Inspector #620 interviewed staff member #107. They stated that they did not investigate the resident's report of being in pain as a result of not receiving the care they required. They also stated that no assessment was conducted of the resident's complaint of pain. Staff member #107 stated that at the time of the complaint they were either unaware of the process to manage such a complaint or that there was no process in place.

Inspector #620 interviewed the Administrator. The Administrator stated that the resident's allegation of not receiving the care they required for in excess of an hour represented an act of neglect. The Administrator also stated that it was the expectation of the home that all allegations of resident neglect were to be immediately investigated. They stated that in the case of this resident, the allegation had not been immediately investigated by the home, and should have been. [s. 23. (1) (a)]

2. The licensee failed to ensure that every alleged, suspected, or witnessed incident of abuse the licensee knew of, or that was reported to the licensee, was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of abuse that was reported to the Director. The CI described an incident of physical abuse that occurred on a specific date. A resident reported being physically abused by staff member #111 which resulted in an injury to the resident.

A review of the home's investigation revealed that staff member #112 became aware of the allegation of physical abuse on a certain date, when it was reported to two staff members by the resident.

Inspector #620 interviewed staff member #107. They stated that staff member #112 became aware of the physical abuse of the resident and sent an email to them on the date staff member #112 became aware. Staff member #107 stated that they did not read the email until two days after the email was sent, because the incident occurred on a weekend when they were not scheduled to work; therefore, the incident was not investigated by the home until two days following staff member #112's knowledge of the physical abuse.

Staff member #107 stated that it was the expectation of the home that all incidents of physical abuse to residents by staff be investigated immediately upon becoming aware of the abuse. They indicated that in regards to the physical abuse involving this resident by

staff member #111, immediate investigation of the allegation of physical abuse had not occurred, and should have. [s. 23. (1) (a)]

3. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse the licensee knew of, or that was reported to the licensee, was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of abuse, reported by the home to the Director.

The CI described an allegation of staff to resident sexual abuse. A resident alleged that staff member #114 sexually abused them.

A review of the home's investigation revealed that staff member #115 received the allegation of sexual abuse on a specific date. Staff member #115 notified staff member #113 of the allegation. Staff member #113 then sent an email to staff member #107 on the same date that the incident was alleged to have occurred.

A progress note indicated that staff member #115 was notified by the resident earlier that morning that they had been touched inappropriately by a staff member the day before. The progress note also indicated that staff member #118 notified staff member #107 of the allegation by email the same date that the incident was alleged to have occurred.

Inspector #620 interviewed staff member #107. They stated that they first became aware of the resident's allegation of sexual abuse by staff member #114 the day following the allegation. Staff member #107 stated that an email was sent to them by staff member #118. Staff member #107 stated that they did not read the correspondence until a day following the allegation because it occurred outside of their regularly scheduled working hours.

Staff member #107 stated that it was the home's expectation that allegations of sexual abuse would be reported immediately by staff to a senior manager on call. They further stated that it was the expectation of the home that all allegations of sexual abuse were to be investigated immediately following the allegation/suspicion. They also stated that the allegation of sexual abuse involving this resident had not been immediately investigated by the home, and should have been. [s. 23. (1) (a)]

4. The licensee failed to ensure that every alleged, suspected or witnessed incident of

abuse of residents by anyone was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of abuse, reported by the home to the Director.

The CI report described an incident of staff to resident abuse; whereby, a resident alleged that a staff member physically abused them. The CI report noted that the resident described the incident as, “upsetting”; they also stated that the staff member was often in a bad mood.

A review of the home’s investigation revealed that staff member #116 and #117 were first made aware of the allegation of physical abuse when the resident approached them and disclosed that they had been hit by another staff member.

The home’s investigation also revealed that the resident did not want to state who was responsible and when the incident had occurred; therefore, the home was unable to determine the identity of the staff member involved. The home concluded their investigation; no action was pursued as the resident was unwilling to talk further about the incident.

Inspector #620 interviewed staff member #107. They stated that they first became aware of the allegation through an email from staff #116, a day after staff member #116 and #117 were first made aware of the allegation. They also stated that it was the home's expectation that incidents of physical abuse be investigated immediately; in the case of the allegation of physical abuse involving this resident by a staff member, this had not occurred, and should have. [s. 23. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure,

(a) that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences;

(b) that the changes and improvements were promptly implemented; and

(c) that a written record of everything provided for in (a) and (b) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

A review of the home's Abuse/Neglect Policy and Procedure titled, "Abuse: Resident Abuse/Neglect" revealed a last revision date of March 19, 2013.

Inspector #620 interviewed staff member #101. They stated that the Resident Abuse/Neglect Policy had not been evaluated since March 19, 2013. They further stated that it was the expectation of the home that the policy was to be evaluated annually, and that this had not occurred, and should have.

Inspector #620 interviewed the Administrator. The Administrator confirmed that the home's Prevention of Abuse/Neglect Policy had not had an annual review since March 19, 2013. The Administrator stated that it was the home's expectation that the policy to promote zero tolerance of abuse and neglect of residents be reviewed annually; they further stated that the home had not undertaken an annual review, and should have. [s. 99. (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

Inspector #620 reviewed a CI related to alleged abuse that was reported to the Director. The CI described an incident of physical abuse. A resident reported being physically abused by staff member #111, which resulted in an injury.

A review of the home's investigation revealed that staff member #112 became aware of the allegation of physical abuse when two staff members notified them that the resident stated they had been physically abused. As a result of the home's investigation, it was determined that staff member #111 was responsible for the abuse of the resident.

Inspector #620 interviewed the resident. The resident stated that they were struck by staff member #111. The resident stated that it caused pain and left an injury.

Inspector #620 interviewed staff member #107. They stated that staff member #111 physically abused the resident and should not have. They also stated that no police were contacted as a result of the physical abuse of the resident by staff member #111.

Inspector #620 interviewed the Administrator. The Administrator stated that it was the home's expectation that incidents involving staff to resident assault should be reported to the police. The Administrator stated that in the CI involving this resident, the home had reasonable grounds to suspect that an assault had occurred. They also stated that the police had not been notified, and should have been. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #4: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The license failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #620 reviewed a CI related to an allegation of neglect that was reported to the Director.

The CI stated that a resident was woken by staff member #104 in the night. The resident informed the staff member that they were not supposed to be woken during the night. The resident then asked staff member #104 for other care assistance. The resident alleged that the staff member refused to provide them with the assistance required.

The resident's care plan advised staff not to wake the resident during the night.

A review of the home’s investigation revealed that staff member #104 was not aware that resident #003 was not to be woken. The home’s investigation indicated that staff member #104 stated that they did not have sufficient time to review the care plan before providing care to the resident.

A letter from the home, addressed to staff member #104, stated that it was, "the employer’s expectation that you will provide care to the resident as indicated in his/her Kardex.”

Inspector #620 interviewed staff member #104. They stated that they did wake the resident and this resulted in the resident becoming angry. They also stated they were not aware that the resident was not to be woken, and they did not review the care plan before providing care.

Inspector #620 interviewed staff member #101. They stated that the resident's a care plan advised staff not to wake the resident at night. They also stated that it was the expectation of the home that the care set out in the plan of care was to be provided as specified in the plan. Staff member #101 further stated that in the CI involving this resident, the care had not been provided as set out in the care plan, and should have been. [s. 6. (7)]

WN #5: 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 failed to ensure that a person who had reasonable grounds to suspect that physical abuse of a resident by the license or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #620 reviewed a CI related to alleged abuse reported to the Director. The CI described an incident of physical abuse; whereby, a resident reported being struck by staff member #111, which resulted in an injury.

A review of the home's investigation revealed that staff member #112 became aware of the allegation of physical abuse when it was reported to two staff members by the resident. As a result of the home's investigation it was determined that staff member #111 was responsible for the abuse of the resident.

Inspector #620 interviewed staff member #107. They stated that staff member #112 became aware of the physical abuse of the resident on a certain date. Staff member #107 revealed that staff member #112 sent an email to them on the same day the incident of physical abuse was alleged. They further stated that they did not read the

email until two days following the allegation because the incident occurred on a weekend when they were not scheduled to work; therefore, the incident was not reported to the Director until two days following the allegation.

Staff member #107 stated that it was the expectation of the home that incidents of physical abuse to residents by staff be reported to the Director immediately. They also indicated that in the incident of physical abuse toward this resident by staff member #111, immediate notification to the Director had not occurred, and should have. [s. 24. (1)]

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

Inspector #620 reviewed a CI related to alleged abuse, reported by the home to the Director. The CI described an allegation of staff to resident sexual abuse. A resident alleged that staff member #114 sexually abused them.

A review of the home's investigation revealed that staff member #115 first received the allegation of sexual abuse on a specific date. Staff member #113 sent an email to staff member #107 on the date the allegation was made to notify them of the alleged incident of sexual abuse.

A progress note indicated that staff member #115 was notified by the resident that they had been touched inappropriately by a staff member the day before. The progress note also indicated that staff member #118 notified staff member #107 via email of the allegation on that day.

Inspector #620 interviewed staff member #107. They stated that they first became aware of the resident's allegation of sexual abuse by staff member #114 on a specific date. Staff member #107 stated that an email was sent to them on the same day that the allegation was made. They also stated that they did not read the correspondence until a day following the allegation because it occurred outside of their regularly scheduled working hours.

Staff member #107 stated that it was the home's expectation that allegations of sexual abuse would be reported immediately by staff to a senior manager on call. They further

stated that it was the expectation of the home that all allegations of sexual abuse were to be reported to the Director immediately following the allegation/suspicion; staff member #107 stated that in the allegation of sexual abuse involving this resident, an immediate report to the Director had not occurred, and should have. [s. 24. (1)]

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

Inspector #620 reviewed a CI related to an allegation of abuse, reported by the home to the Director. The CI report described an incident of staff to resident abuse; whereby, a resident alleged that a staff member physically abused them. The CI report noted that the resident described the incident as, "upsetting"; they also stated that the staff member was often in a bad mood and that the incident was upsetting.

A review of the home's investigation revealed that staff member #116 and #117 were first made aware of the allegation of physical abuse when resident #007 approached them and advised them that they had been hit by another staff member.

Inspector #620 interviewed staff member #107. They stated that it was the home's expectation that incidents of physical abuse were to be reported to the Director immediately; in the allegation of physical abuse involving this resident by a staff member this had not occurred, and should have.[s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the that resident's SDM was notified immediately upon the licensee becoming aware of an alleged, suspected, or witnessed incident of abuse of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could have potentially been detrimental to the resident's health or well-being.

Inspector #620 reviewed a CI related to an allegation of abuse, reported to the Director. The CI described an incident of physical abuse. A resident reported being struck by staff member #111 which resulted in an injury.

A review of the home's investigation revealed that staff member #112 became aware of the allegation of physical abuse when it was reported to two staff members by the resident.

Inspector # 620 interviewed the SDM for the resident. The SDM stated that the home did not contact them or a second SDM until two days following the incident. The SDM expressed that they advised the home that they should have been called on the night the home became aware of the physical abuse.

Inspector #620 interviewed staff member #107. They stated that staff member #112 became aware of the physical abuse of resident #005 a specific date. They also revealed that staff member #112 sent an email to them on the day the allegation was made, advising them of the incident of physical abuse. Staff member #107 stated that they did

not read the email until two days after the initial allegation because the incident occurred on a weekend when they were not scheduled to work; therefore, the incident was not investigated by the home until two days following staff member #112's knowledge of the physical abuse, nor was the SDM notified.

Staff member #107 stated that it was the expectation of the home that incidents of physical abuse toward residents by staff be reported to the SDM immediately. Staff member #107 indicated that in this incident of physical abuse toward this resident by staff member #111, immediate notification to the SDM had not occurred, and should have. [s. 97. (1) (a)]

2. The licensee failed to ensure that the resident's substitute decision-maker was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could have been potentially detrimental to the resident's health or well-being.

Inspector #620 reviewed a CI related to an allegation of abuse, reported by the home to the Director. The CI described an allegation of staff to resident sexual abuse. A resident alleged that staff member #114 sexually abused them.

A review of the home's investigation revealed that staff member #115 first received the allegation of sexual abuse on a certain date. Staff member #113 sent an email to staff member #107 to notify them of the allegation of sexual abuse on the same day.

A progress note indicated that staff member #115 was notified by the resident earlier that morning that they had been touched inappropriately by a staff member the day before. The progress note also indicated that staff member #118 notified staff member #107 of the allegation by email on the same day the allegation was made.

Inspector #620 interviewed staff member #107. They stated that they first became aware of the resident's allegation of sexual abuse by staff member #114 on a certain day. Staff member #107 stated that an email was sent to them on the same day that the allegation was made. They further stated that they did not receive the correspondence until a day following the allegation because they were not working.

Staff member #107 stated that it was the home's expectation that allegations of sexual abuse would be reported immediately by staff to a senior manager on call. They further

stated that it was the expectation of the home that all allegations of sexual abuse were to be reported to the SDM immediately following the allegation/suspicion. Staff member #107 stated that the allegation of sexual abuse involving resident #006 had not been immediately reported to the SDM, and should have been. [s. 97. (1) (a)]

Issued on this 12th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALAIN PLANTE (620)
Inspection No. / No de l'inspection :	2016_336620_0004
Log No. / Registre no:	032422-15, 031034-15, 031621-15, 031762-15, 027496-15, 000581-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 11, 2016
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Loubert

To THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

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Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall:

a) review and revise the home's process to ensure that an investigation following witnessed, suspected, or reported incidents of resident abuse/neglect is completed;

b) maintain a record of the review and what revisions were required;

c) train all staff on the home's revised process to ensure immediate investigation of witnessed, suspected, or reported incidents of resident abuse/neglect;

d) maintain a record of all staff training related to this process.

Grounds / Motifs :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of residents by anyone was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of abuse, reported by the

home to the Director.

The CI report described an incident of staff to resident abuse; whereby, a resident alleged that a staff member physically abused them. The CI report noted that the resident described the incident as, "upsetting"; they also stated that the staff member was often in a bad mood.

A review of the home's investigation revealed that staff member #116 and #117 were first made aware of the allegation of physical abuse when the resident approached them and disclosed that they had been hit by another staff member.

The home's investigation also revealed that the resident did not want to state who was responsible and when the incident had occurred; therefore, the home was unable to determine the identity of the staff member involved. The home concluded their investigation; no action was pursued as the resident was unwilling to talk further about the incident.

Inspector #620 interviewed staff member #107. They stated that they first became aware of the allegation through an email from staff #116, a day after staff member #116 and #117 were first made aware of the allegation. They also stated that it was the home's expectation that incidents of physical abuse be investigated immediately; in the case of the allegation of physical abuse involving this resident by a staff member, this had not occurred, and should have. [s. 23. (1) (a)] (620)

2. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse the licensee knew of, or that was reported to the licensee, was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of abuse, reported by the home to the Director.

The CI described an allegation of staff to resident sexual abuse. A resident alleged that staff member #114 sexually abused them.

A review of the home's investigation revealed that staff member #115 received the allegation of sexual abuse on a specific date. Staff member #115 notified staff member #113 of the allegation. Staff member #113 then sent an email to

staff member #107 on the same date that the incident was alleged to have occurred.

A progress note indicated that staff member #115 was notified by the resident earlier that morning that they had been touched inappropriately by a staff member the day before. The progress note also indicated that staff member #118 notified staff member #107 of the allegation by email the same date that the incident was alleged to have occurred.

Inspector #620 interviewed staff member #107. They stated that they first became aware of the resident's allegation of sexual abuse by staff member #114 the day following the allegation. Staff member #107 stated that an email was sent to them by staff member #118. Staff member #107 stated that they did not read the correspondence until a day following the allegation because it occurred outside of their regularly scheduled working hours.

Staff member #107 stated that it was the home's expectation that allegations of sexual abuse would be reported immediately by staff to a senior manager on call. They further stated that it was the expectation of the home that all allegations of sexual abuse were to be investigated immediately following the allegation/suspicion. They also stated that the allegation of sexual abuse involving this resident had not been immediately investigated by the home, and should have been. [s. 23. (1) (a)] (620)

3. The licensee failed to ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that the licensee knew of, or that was reported to the licensee, was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of neglect that occurred on a specific date and was reported to the Director three days following the occurrence.

The CI described an incident involving a resident. The resident reported that staff member #108 attempted to wash their face with a soiled cloth. This occurred the same day that the resident had reported an incident of neglect; whereby, the resident was required to wait in excess of an hour to receive the care they required.

A review of the home's investigation revealed that the resident reported not receiving the care they required from staff member #107. The home's investigation documents further revealed that the resident reported that they made numerous attempts to have staff provide them assistance. Furthermore, the resident reported that they waited in excess of an hour and was in pain due to the extended wait.

Inspector #620 interviewed the resident. The resident stated that no staff member of the home had advised them of the outcome of their initial complaint of not receiving the care they required for in excess of an hour. The resident also stated that no staff member assessed their concerns of being in pain following the incident.

Inspector #620 interviewed staff member #107. They stated that they did not investigate the resident's report of being in pain as a result of not receiving the care they required. They also stated that no assessment was conducted of the resident's complaint of pain. Staff member #107 stated that at the time of the complaint they were either unaware of the process to manage such a complaint or that there was no process in place.

Inspector #620 interviewed the Administrator. The Administrator stated that the resident's allegation of not receiving the care they required for in excess of an hour represented an act of neglect. The Administrator also stated that it was the expectation of the home that all allegations of resident neglect were to be immediately investigated. They stated that in the case of this resident, the allegation had not been immediately investigated by the home, and should have been. [s. 23. (1) (a)] (620)

4. The licensee failed to ensure that every alleged, suspected, or witnessed incident of abuse the licensee knew of, or that was reported to the licensee, was immediately investigated.

Inspector #620 reviewed a CI related to an allegation of abuse that was reported to the Director. The CI described an incident of physical abuse that occurred on a specific date. A resident reported being physically abused by staff member #111 which resulted in an injury to the resident.

A review of the home's investigation revealed that staff member #112 became aware of the allegation of physical abuse on a certain date, when it was reported

to two staff members by the resident.

Inspector #620 interviewed staff member #107. They stated that staff member #112 became aware of the physical abuse of the resident and sent an email to them on the date staff member #112 became aware. Staff member #107 stated that they did not read the email until two days after the email was sent, because the incident occurred on a weekend when they were not scheduled to work; therefore, the incident was not investigated by the home until two days following staff member #112's knowledge of the physical abuse.

Staff member #107 stated that it was the expectation of the home that all incidents of physical abuse to residents by staff be investigated immediately upon becoming aware of the abuse. They indicated that in regards to the physical abuse involving this resident by staff member #111, immediate investigation of the allegation of physical abuse had not occurred, and should have. [s. 23. (1) (a)] (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

The licensee shall:

a) ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

b) ensure that the changes and improvements to the policy as required in the evaluation are promptly implemented; and

c) that a written record of everything provided for in (a) and (b) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Grounds / Motifs :

1. The licensee failed to ensure,

(a) that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences;

(b) that the changes and improvements were promptly implemented; and

(c) that a written record of everything provided for in (a) and (b) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

A review of the home's Abuse/Neglect Policy and Procedure titled, "Abuse: Resident Abuse/Neglect" revealed a last revision date of March 19, 2013.

Inspector #620 interviewed staff member #101. They stated that the Resident Abuse/Neglect Policy had not been evaluated since March 19, 2013. They further stated that it was the expectation of the home that the policy was to be evaluated annually, and that this had not occurred, and should have.

Inspector #620 interviewed the Administrator. The Administrator confirmed that the home's Prevention of Abuse/Neglect Policy had not had an annual review since March 19, 2013. The Administrator stated that it was the home's expectation that the policy to promote zero tolerance of abuse and neglect of residents be reviewed annually; they further stated that the home had not undertaken an annual review, and should have. [s. 99. (b)] (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alain Plante

Service Area Office /
Bureau régional de services : Sudbury Service Area Office