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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 3, 2017	2017_613609_0002	023255-16, 026250-16, 029978-16, 032867-16, 032887-16, 001335-17	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

CHAD CAMPS (609), SYLVIE BYRNES (627)

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 9-13 and January 16-19, 2017.

This Critical Incident Inspection was related to: One Critical Incident (CI) report the home submitted to the Director related to family to resident abuse; Three CI reports the home submitted to the Director related to staff to resident abuse; One CI report the home submitted related to a resident fall and; One CI report the home submitted to the Director related to allegations of resident sexual abuse.

A Complaint Inspection #2017_613609_0003 and a Follow Up Inspection #2017_613609_0001 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MRC), Manager of Administration, Manager of Physical Services (MPS), Program Coordinators (PCs), Intake Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Maintenance Workers, Health Care Aides (HCAs), Schedulers, residents and family of residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staffing schedules, staff training records, components of human resource files, internal investigations, policies, procedures, programs and annual program evaluation records.

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

During the course of this inspection, Non-Compliances were issued.

- **1 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 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 has failed to ensure that appropriate action was taken in response to every such incident of alleged, suspected or witnessed abuse or neglect of the resident.

A Critical Incident (CI) report was submitted to the Director which alleged that on a particular day, HCA #131 neglected as well as emotionally and verbally abused residents #050 and #051.

Inspector #609 reviewed the home's internal investigation and found the allegations of abuse and neglect of residents #050 and #051 were substantiated 10 days later and HCA #131 received disciplinary action.

During an interview with Program Coordinator (PC) #116 on January 18, 2017, they verified that they lead the home's internal investigation into the allegations of abuse and neglect of residents #050 and #051. PC #116 indicated that after the allegations were made, HCA #131's was interviewed by PC #116 on their next scheduled shift.

A review of HCA #131's schedule found that they continued to work in the home for two afternoon shifts while the home's investigation was ongoing.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" last revised February 4, 2016, indicated that steps would be taken to ensure that the alleged perpetrator would have no possibility of committing similar or other offenses against other

residents. Some of the steps outlined in the policy included immediate suspension of the perpetrator pending the outcome of the investigation or reassignment to a non-resident area.

During the same interview with PC #116 on January 18, 2017, they verified that they moved HCA #131 to another unit after the allegations of neglect and abuse were made, where they provided direct care to residents while the outcome of the investigation was pending. The home's internal investigation resulted in the allegations of neglect and abuse being substantiated and HCA #131 receiving a specified disciplinary action.

PC #116 failed to provide any interventions, measures or safeguards that the home put in place to have ensured that HCA #131 did not abuse any other residents while an investigation was ongoing.

The PC further acknowledged that even after the allegations of abuse and neglect were substantiated, no further interventions, measures or safeguards were put in place to ensure that residents were protected from abuse while HCA #131 continued to work and provide direct care on other units. [s. 23. (1) (b)]

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 appropriate action is taken in response to every such incident of alleged, suspected or witnessed abuse or neglect of the resident, to be implemented voluntarily.

Issued on this 3rd day of March, 2017

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

Original report signed by the inspector.