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 prévue le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 23, 2017;	2017_613609_0001 (A1)	014860-16, 030474-16, 030476-16	Follow up

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

MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Good Morning,

Attached is the amended public inspection report with an extended compliance due date as requested.

Thanks
Michelle Berardi
LTCH Inspector-Nursing.

Issued on this 23 day of June 2017 (A1)

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

Original report signed by the inspector.

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MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 9-13 and January 16-19, 2017.

This Follow Up Inspection is related to eight Compliance Orders (COs) related to resident bed rail systems, domestic water temperatures, clear direction in the plan of care, protection of residents from abuse and neglect, compliance with the zero tolerance of abuse and neglect policy, steps to minimize the risk of altercations and potentially harmful interactions between residents, compliance with any plan, policy, protocol, procedure, strategy or system put in place by the home and the staffing plan meeting the assessed care and safety needs of residents.

A Critical Incident Inspection #2017_613609_0002 and a Complaint Inspection #2017_613609_0003 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:

Personal Support Services

Safe and Secure Home

Sufficient Staffing

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

- **5 WN(s)**
- **1 VPC(s)**
- **4 CO(s)**
- **3 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_269627_0011	609
O.Reg 79/10 s. 54.	CO #004	2016_320612_0010	609
LTCHA, 2007 s. 6. (1)	CO #001	2016_320612_0010	609
O.Reg 79/10 s. 8. (1)	CO #005	2016_320612_0010	609

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius.

A previous Compliance Order (CO) was issued to the home on September 27, 2016, to address the licensee's failure to comply with s. 90. (2) of O.Reg. 79/10 during the Resident Quality Inspection (RQI) #2016_269627_0011.

The CO required the licensee to: ensure that the hot water serving showers, tubs, and hand basins, which were accessible to residents, was maintained at a temperature of at least 40 degrees Celsius and not exceeding 49 degrees Celsius and; that immediate action was taken to reduce the water temperature if it exceeded 49 degrees Celsius.

Full compliance with the CO was expected by October 31, 2016.

On a particular day, Inspector #609 took the temperature of the water in the dining room of Park Place unit at 1415 hours and found it to be 50.0 degrees Celsius while the temperature of the water at the hand basin of room 116 on Park Place was 51.1 degrees Celsius at 1420 hours.

A review of the home's policy titled "Water Temperature Monitoring" last revised December 27, 2016, indicated that hot water serving all bathtubs, showers and hand basins used by residents shall range between 40-49 degrees Celsius.

A review of the home's daily domestic water temperature monitoring records for the 71 days between October 31, 2016 and January 9, 2017, found 68 or 96 per cent of the days had recorded water temperatures that exceeded 49 degrees Celsius, with some values recorded as high as 55.3 degrees Celsius on December 5, 2016.

During an interview with the Manager of Physical Services (MPS), they acknowledged fluctuations in the home's water temperatures that exceeded 49 degrees Celsius. [s. 90. (2) (g)]

2. The licensee has failed to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius.

On a particular day, Inspector #609 took the temperature of the water in the dining room of York unit at 1500 hours and found it to be 55.0 degrees Celsius.

A review of the home's daily domestic water temperature monitoring records for the 71 days between October 31, 2016, and January 9, 2017, found 68 or 96 per cent of the days had recorded water temperatures that exceeded 49 degrees Celsius.

A review of the home's policy titled "Water Temperature Monitoring" last revised December 27, 2016, indicated that once notified of hot water temperature issues, the MPS was to take immediate actions to remedy the situation. All resident home areas were to be advised of either high or low water temperatures that were expected for more than 15 minutes and appropriate measures were to be taken to rectify the situation and ensure resident safety.

During an interview with Inspector #609, Maintenance Worker #110 indicated that when water temperatures were recorded that exceeded 49 degrees Celsius, a phone call or email was sent to the MPS outlining the water temperature concerns.

Maintenance Worker #110 was unable to describe what immediate measures were to be taken to rectify the water temperature exceeding 49 degrees Celsius or how they would be able to know when the temperature was expected to be out of range for longer than 15 minutes.

During an interview with Inspector #609, RPN #109 verified that maintenance staff checked water temperatures often but had never been given direction or what to do when the temperature exceeded 49 degrees Celsius to ensure resident safety.

During an interview with RPN #111 verified that maintenance staff checked water temperatures on the unit but had never been given any directions or measures to ensure resident safety when the water temperature exceeded 49 degrees Celsius.

During an interview with the Administrator and MPS, a review of the domestic water temperature record was conducted and both acknowledged recorded values exceeding 49 degrees Celsius. The MPS indicated that when a value exceeding 49 degrees Celsius was recorded by maintenance staff they were to continue on with the monitoring to establish if other areas of the home were experiencing the same concern. The MPS was unable to provide any record of any actions taken to immediately reduce the water temperature when found to exceed 49 degrees Celsius, to ensure resident safety. [s. 90. (2) (h)]

3. The licensee has failed to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

On a particular day, Inspector #609 took the temperature of the water in the hand basin in room 122 on Killarney unit at 1130 hours, and found it to be 32.7 degrees Celsius.

On a particular day, the water temperature in the Pine unit tub room at 1020 hours was 39 degrees Celsius while the shower in Pine unit was found to be 36.1 degrees Celsius which were verified at the time of recording with HCA #114. At 1450 hours the York unit tub room hand basin was 37.7 while the hand basin in York unit room 119 was 31.1 degrees Celsius at 1455 hours.

During an interview with the Inspector, HCA #114 indicated that low water temperatures had been an ongoing issue. HCA #114 was unable to describe any measures to be taken when water temperatures were lower than 40 degrees

Celsius and went on to state that baths were still provided to residents the week previously when the tub water temperature only reached 34 degrees Celsius.

During an interview with resident #007 on a particular day, they described that for at least the past four weeks the water temperature for bathing had been cool.

During an interview with resident #008 on a particular day, they described how between 1000 and 1100 hours daily, the water was cold.

During an interview with resident #009 on a particular day, they stated that two weeks previously the water was so cold in the tub room that they were unable to have a bath and were instead given a sponge bath in bed.

A review of the home's daily domestic water temperature monitoring records between October 31, 2016, and January 9, 2017, found that the water temperature on December 18, 2016, for a specific unit was 37.1 degrees Celsius, on December 28, 2016, 38.3 degrees Celsius and 38.5 degrees Celsius on January 3, 2017.

A review of the shift to shift "Daily Report- Resident Care" for an identified unit during a one week period in January 2017 found that on two days hot water was unavailable for baths after 1000 hours. The report also indicated that resident #016 missed their bath as a result of no available hot water on one of the days.

A review of the plan of care for resident #016 indicated that they preferred a bath.

A review of the Point of Care (POC) documentation for resident #016 on the specified day, indicated that the resident was provided a bed bath.

A review of the home's policy titled "Water Temperature Monitoring" last revised December 27, 2016, indicated that hot water serving all bathtubs, showers and hand basins used by residents shall range between 40-49 degrees Celsius.

During an interview with the MPS, they acknowledged fluctuations in the home's water temperatures that were below 40 degrees Celsius and that this was an ongoing issue. [s. 90. (2) (i)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A previous CO was issued on May 24, 2016, to address the licensee's failure to comply with s.31 (3) of O.Reg. 79/10 during Follow Up Inspection #2016_320612_0010(A1).

The CO required the licensee to; ensure that their staffing mix was evaluated and updated to ensure that the residents' care and safety needs were met; that all residents received their preferred and scheduled bath as identified in their plan of care and; that a record was kept of the evaluation including who participated in the review, the date of the review, the changes made and the date the changes were implemented.

Full compliance of the CO was expected by June 14, 2016.

A) A review of the home's shift to shift reports was conducted by Inspector #609 for a two week period between December 2016 and January 2017 which found that seven of the 14 days or 50 per cent of the time, during the two week period, between one to six residents on a unit had not received their preferred or scheduled bath.

A further review of the home's HCA schedule was conducted with Scheduler #122 for specified days between December 2016 and January 2017 which found that where residents' preferred or scheduled baths were not provided, every unit had been short HCA staff of between 2.5 to 7.5 hours during a single shift.

A review of health care records found that the HCA staff shortages on particular days impacted residents as follows:

-Park Place unit was short one full afternoon shift which resulted in resident #019, #020 and #021 not receiving a tub bath as per their plans of care;

-Park Place unit was short one full afternoon shift which resulted in resident #022, #023, #024, #025 not receiving a tub bath as per their plans of care;

-Cranberry unit was short a partial day shift which resulted in resident #026 not receiving a shower as per their plan of care;

-Cranberry unit was under staffed using a modified worker in the afternoon who was unable to perform HCA duties which resulted in resident #027, #028, #029,

#030, #031 not receiving a shower or tub bath as per their plans of care;

-Cranberry unit was short half an afternoon shift which resulted in resident #032, #033, #034 not receiving their tub baths as per their plans of care. Lilac-Mallard (LM) unit was short a partial day shift and half an afternoon shift which resulted in resident #036, #037, #038 not receiving a tub bath as per their plans of care;

-Park Place unit was short half an afternoon shift which resulted in resident #020, #021, #023, #039, #040 not receiving a tub bath as per their plans of care. Pine unit was short one full day shift which resulted in resident #041, #042 not receiving a tub bath as per their plans of care and;

-Pine unit was short a full day shift which resulted in resident #043, #044, #045 not receiving a tub bath as per their plans of care.

B) During an interview with HCA #119, they verified that they were present and working on a particular day on one of the units which was short one full HCA shift. They went on to describe that when short of staff as they were on the particular day, the preferred and scheduled showers or tub baths were not performed and that a complete bed bath was to be provided for the resident's scheduled bath.

A review of the home's policy titled "Personal Care- Bathing: Complete, Partial, Tub Bath, or Shower" last revised December 21, 2015, indicated that when working at minimum staffing levels in a unit, staff were expected to provide all residents care as per their plans of care and if unable to provide a resident with their bath of choice, the resident was to be offered a complete bed bath and hair wash in bed. The policy further indicated that bed bathing also included foot care and cleaning and trimming of fingernails and toenails.

During an interview with HCA #123, they verified that they were present and working on a specific unit on a particular day, which was short a full afternoon shift. They further verified that they documented resident #029 as a complete bath yet sponged the resident as they sat on the toilet.

During an interview with Scheduler #124, they indicated that another specific unit was short a full day shift HCA as well as a full afternoon shift HCA on a particular day.

A review of the shift to shift report for the specified unit on the particular day,

indicated that no baths were given that day related to shortages of staff.

During an interview with resident #048, they verified that they had not received a tub bath as per their plan of care on the particular day. They further described that they were assisted to lightly sponge bath at the sink in their room and that the care was not provided in bed.

During an interview with RPN #129, they indicated that when short of HCA staff and baths could not be completed, the more independent residents like resident #048 would be sponge bathed at the sink.

A review of resident #047's plan of care indicated that on a particular day, the resident was to have received a complete bed bath which included nail care and trimming, yet observations next day of resident #047 noted the resident had long, untrimmed fingernails with dark crusted debris underneath.

A review of resident #047's health care records found that on the particular day, the HCA documented "not applicable" for the required nail care.

During an interview with the Manager of Resident Care (MRC), they verified that when short of HCA staff a complete bed bath was to be provided to the residents, defined as thorough cleanse in the resident's bed which included hair and nail care. The MRC indicated that over the next month education would be provided to staff as to what was expected when giving a complete bed bath and that sponging residents at the sink would not qualify as a complete bed bath.

C) The home provided a document which tabulated a quarterly percentage of how many residents received their preferred and scheduled baths titled "Bath Audits". A review of the home's "Bath Audits" found that between 14 and 18 per cent of residents' preferred baths over the last two quarters in 2016 were not provided due to shortages of staff.

A review of the home's policy titled "Personal Care- Bathing : Complete, Partial, Tub Bath, or Shower" last revised December 21, 2015, indicated that each resident was to be offered a bath at a minimum, twice a week by a method of his or her choice.

During an interview with the MRC, a review of the home's "Bath Audits" was conducted. The MRC verified that it was the goal of the home that each resident

was provided with a minimum of two baths of their choosing per week. The MRC acknowledged that with an average of 18 per cent of residents not provided with their chosen baths during the 2016 year related to staffing shortages, the home still had improvements to make.

D) During an interview with the MRC, they indicated that the home's working short of staff contingency plan was updated in August 2016.

During the same interview with the MRC, the home's "Resident Care Section Staffing Contingency Plan" last revised August 9, 2016 was reviewed which indicated that anytime there were seven residents in the home who had not received a bath of their choice due to a unit working below the minimum staffing level, the night RN would send out a request for additional staff (staff stat) between 0530 and 0600 hours requesting a HCA work 0900 to 1700 hours the next day to provide those residents a bath.

A review of the home's shift to shift reports was conducted for a two week period between December 2016 and January 2017 which found that on a particular day, a total of eight residents did not receive a bath related to HCA staff shortages.

During an interview with the MRC, they indicated that the RN on night shift, did not follow the home's contingency plan and as a result did not call in additional HCA staff to make up the missed baths. The MRC acknowledged that additional training was required to ensure that the night RNs call in additional staff when seven or more residents did not receive a bath of their choice during a single day. [s. 31. (3)]

Additional Required Actions:

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

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the license or staff.

A previous CO was issued on May 3, 2016, to address the licensee's failure to comply with s. 19.(1) of the LTCHA, 2007, during Follow Up Inspection #2016_320612_0010(A1).

The CO required the licensee to: retrain all staff related to the home's abuse policy and; keep a written record of the retraining.

Full compliance of the CO was expected by September 6, 2016.

Upon Follow Up inspection, while the home completed all the required retraining, a concurrent Complaint inspection #2017_613609_0003 was performed which found the following non-compliance:

The Long-Term Care Homes (LTCH) Act, 2007 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being" and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to Director which alleged that resident #006 was not well on a particular day and exhibited specific symptoms. The complainant further

indicated that the resident's health status deteriorated, was transferred to the hospital and diagnosed with a specified illness.

A review of physician #134's hospital report indicated that resident #006 had a specified illness.

Inspector #627 reviewed resident #006's plan of care for the week prior to the resident's hospital admission which indicated that they needed an identified level of care from staff.

A review of resident #006's progress notes during a one week period prior to their transfer to hospital, established a timeline of the resident's progressive deterioration. On a particular day the resident was noted to be exhibiting symptoms. The initial entry was followed by 20 additional progress notes documenting the resident's continued symptoms which resulted in the resident being transferred to the hospital on a particular cay.

A review of the home's policy titled "Case Definition For Urinary Tract Infections", last revised December 15, 2013, indicated a resident may have a symptomatic urinary tract infection if at least three of the following signs and symptoms were present: Fever, new or increasing burning pain on urination, frequency, urgency, new flank or suprapubic pain or tenderness, change in character of urine, worsening of mental or functional status, for example decreased appetite, falls, change in sleep pattern, behavior changes, agitation or drowsiness.

A review of the home's policy titled, "Vital Signs: Temperature, Pulse, Respiration, Blood Pressure and Pain" last revised July 28, 2016, indicated that residents were to have their vitals assessed by qualified staff on a routine basis and in case of a change in their conditions.

A review of the home's policy titled "Physician Group Medical Directives" issued March 17, 2008, indicated that urine for culture and sensitivity (C&S) was to be collected if symptoms indicated.

A review of resident #006's health care records found no head to toe assessments, no documented temperature and no specific lab testing prior to the resident's hospitalization.

A review of the home's physician communication binder found entries on four

particular days, indicating that resident #006 was symptomatic. There was no further entries to communicate the resident's ongoing and increasing symptoms.

During an interview with resident #006's family member they stated that the resident "did not look well", the week prior to their hospital admission. When they came to visit, they found the resident "looked like they were dying". They then called the SDM and advised them of their concerns and that the SDM should call physician #136 immediately.

During an interview with resident #006's SDM they stated prior to the hospital admission, resident #006 had told them and stated they did not feel well. The SDM stated that they called the home on a particular day, and spoke to physician #136 who stated that resident #006 seemed to have improved. Two days later the SDM received a call from a family member who had visited with resident #006. The family member informed the SDM that the resident was not looking well and that they should call the physician to discuss. The SDM stated that they had followed up with the home two days later and had spoken to a nurse who stated that they would make the physician aware of their concerns and that they were monitoring the resident very closely. Two days after that the SDM called the home and spoke with an RN who told the SDM that the resident "looked like they were on their death bed". The SDM stated that they had called physician #136 and insisted that the resident be sent to the hospital.

During an interview with RPN #109 they stated that when a resident presented with a significant change, an assessment was to be done including vital signs which would include the resident's temperature, other symptoms, and level of consciousness. RPN #109 stated that resident #006 was difficult to assess and often demonstrated behaviours and was difficult to determine if the resident was ill or if they were demonstrating behaviours. RPN #109 further stated that they had not completed a head to toe assessment of the resident. RPN #109 stated that they had not inquired about other symptoms. They also stated that a specific lab test should have been completed as many residents presenting with similar symptoms had an infection. RPN #109 stated that the staff had been negligent as they had focused on behaviours and not on a full physical assessment of the resident's decline.

During an interview with RN #123 they stated that when a resident has a significant change, the resident would be monitored by the RN supervisor and that appropriate actions were to be taken. RN #123 further stated that for resident

#006, a specific lab test should have been completed and the physician should have been called to assess as the resident's condition further deteriorated. Vital signs should have been closely monitored on every shift, which would have included taking the resident's temperature. RN #123 stated that this was a situation of treating the resident's deterioration as behavioural and indicated that the staff had been negligent.

During an interview with PC #125 they stated that when a resident had a significant change in condition (as in the case of resident #006) a head to toe assessment was to be completed by a registered staff member, and abnormal findings were to be followed up on with appropriate action. They further stated that resident #006 had appeared very ill in the last few days and that in hindsight, the focus should have been on a comprehensive medical assessment instead of concentrating on the resident's behaviour. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A previous Compliance Order (CO) #003 was issued on May 24, 2016, to address the licensee's failure to comply with s. 20. (1) of the LTCHA, 2007 during Follow Up Inspection #2016_320612_0010(A1).

The CO required the licensee to ensure that: all required staff completed retraining on the home's "Promoting Zero Tolerance of Abuse and Neglect of Residents" policy and; that a written record was kept of the retraining which included who participated in the retraining, when it occurred and what it entailed.

Full compliance with the CO was expected by September 6, 2016.

Upon Follow Up inspection, while the home completed all the required retraining, a concurrent Critical Incident inspection #2017_613609_0002 was performed which found the following non-compliances.

1) A Critical Incident report was submitted to the Director, which outlined allegations of verbal and emotional abuse that occurred on a particular day by HCA #131 toward residents #050 and #051.

Inspector #609 reviewed the home's internal investigation which found that a resident observed HCA #131 dress resident #050 in pajamas to attend the dinner, told the resident that they would not assist them with certain care needs more than once that evening and after dinner placed the resident in bed at 1830 hours. Resident #050 was found by the other resident to be upset after the incident. Resident #050's plan of care directed staff to provide certain assistance as needed as well as assist the resident to bed at a time much later than was provided.

A review of the home's interview with resident #050 found that the resident had not wanted to go to bed at 1830 hours but HCA #131 advised the resident they would not provide certain care.

The home's internal investigation also found that during the same afternoon shift resident #051 had complained of difficulties with their special treatment and

requested the assistance of HCA #131, who argued with the resident that there was no issues with the treatment. HCA #131 further denied resident #051 certain assistance before dinner.

A review of the home's interview with HCA #133 verified they were present and observed HCA #131 argue with resident #051 about their treatment difficulties the resident was experiencing as well as their refusal to assist the resident with certain care before dinner.

The Long-Term Care Homes (LTCH) Act, 2007 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that is performed by anyone other than a resident.

The LTCH Act also defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that are made by anyone other than a resident.

During interviews with resident #050 and #051, they both verified that HCA #131 acted abusively towards them and did not want HCA #131 caring for them anymore.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" last revised February 4, 2016, indicated that residents would be free from abuse by staff.

During an interview with the MRC, they verified that HCA #131 did not comply with the home's abuse policy and received disciplinary action.

2) A CI report was submitted to the Director alleging staff to resident abuse. It was alleged that HCA #128 provided care to resident #035 in a rough and neglectful manner.

Inspector #627 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect", last revised February 4, 2016, which defined neglect as failing to provide a resident with treatment, care, services or assistance to ensure their health, safety or well-being.

The Long-Term Care Homes (LTCH) Act, 2007 further defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During an interview with the Inspector, resident #035's family member stated that they were at the home on a particular day. The following concerns were expressed regarding the care provided to resident #035 by HCA #128:

-HCA #128 brought the resident back to their room and asked the family member to dress resident #035 in their pajamas;

-HCA #128 was going to transfer the resident unsafely, at which time the family member informed them that this was not as per the resident's plan of care;

-HCA #128 grabbed the resident by their clothing to roll them over and used poor technique to provide care to the resident. The HCA then used unsafe and improper technique to move resident #035 which caused the resident to scream in pain and shed tears.The HCA then left for 20 minutes;

-While HCA #128 was gone, the resident soiled themselves and the family member had to assist the resident to cleanse. HCA #128 returned without assisting the resident and then left for another 15 minutes;

-Upon return, HCA #128, once again caused pain to the resident by using improper transfer technique. The HCA then left for the third time, leaving the resident completely uncovered. The family member questioned them, the HCA grabbed the blankets and tossed them up which covered the resident's face. Only after the family member questioned how the blankets were left did they uncover the resident's face and;

-While HCA #128 was in resident #035's room they rudely spoke to the family member that was present and left for an additional 30 minutes.

A review of a letter as part of the internal investigation, found that HCA #128 did not review resident #035's plan of care prior to providing services, appeared to have abandoned the resident for excessive times and "While they insist that they did not behave in an abusive manner it would seem the facts point to a different conclusion. Neglecting to care for the resident was, in itself, an abuse and it was

unacceptable". HCA #128 was subsequently terminated.

During an interview with Inspector #609, the MRC verified that HCA #128 did not comply with the home's policy titled "Abuse: Resident Abuse/Neglect", last revised February 4, 2016. [s. 20. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On January 9, 2017, at 1200 hours Inspector #609 observed the Poplar Place unit's tub room door open and unattended by staff.

A review of the home's policy titled "Door locking" last revised April 22, 2014, indicated that all doors leading to non-residential areas were to be equipped with locks to restrict unsupervised access to those areas by residents.

During an interview with HCA #103 they verified that the Poplar Place tub room was not to have been left open and unlocked when unsupervised and proceeded to close and lock the door.

During an interview with the MRC they verified that tub room doors were not to be left unlocked when unattended by staff to ensure resident safety. [s. 9. (1) 2.]

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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

Issued on this 23 day of June 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MICHELLE BERARDI (679) - (A1)

Inspection No. / No de l'inspection : 2017_613609_0001 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 014860-16, 030474-16, 030476-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jun 23, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_269627_0011, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

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

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

The licensee shall:

a) Ensure the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, regardless of time of day, unit or circumstances.

b) Review, revise, and implement the home's policy titled “Water Temperature Monitoring” to ensure that the policy contains procedures to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

c) Ensure the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, regardless of time of day, unit or circumstances.

Grounds / Motifs :

1. The licensee has failed to ensure the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius.

A previous Compliance Order (CO) was issued to the home on September 27, 2016, to address the licensee's failure to comply with s. 90. (2) of O.Reg. 79/10 during the Resident Quality Inspection (RQI) #2016_269627_0011.

The CO required the licensee to: ensure that the hot water serving showers, tubs, and hand basins, which were accessible to residents, was maintained at a temperature of at least 40 degrees Celsius and not exceeding 49 degrees Celsius and; that immediate action was taken to reduce the water temperature if it exceeded 49 degrees Celsius.

Full compliance with the CO was expected by October 31, 2016.

On a particular day, Inspector #609 took the temperature of the water in the dining room of Park Place unit at 1415 hours and found it to be 50.0 degrees Celsius while the temperature of the water at the hand basin of room 116 on Park Place was 51.1 degrees Celsius at 1420 hours.

A review of the home's policy titled "Water Temperature Monitoring" last revised December 27, 2016, indicated that hot water serving all bathtubs, showers and hand basins used by residents shall range between 40-49 degrees Celsius.

A review of the home's daily domestic water temperature monitoring records for the 71 days between October 31, 2016 and January 9, 2017, found 68 or 96 per cent of the days had recorded water temperatures that exceeded 49 degrees Celsius, with some values recorded as high as 55.3 degrees Celsius on December 5, 2016.

During an interview with the Manager of Physical Services (MPS), they acknowledged fluctuations in the home's water temperatures that exceeded 49 degrees Celsius. (609)

2. The licensee has failed to ensure that immediate action was taken to reduce the

water temperature in the event that it exceeded 49 degrees Celsius.

On a particular day, Inspector #609 took the temperature of the water in the dining room of York unit at 1500 hours and found it to be 55.0 degrees Celsius.

A review of the home's daily domestic water temperature monitoring records for the 71 days between October 31, 2016, and January 9, 2017, found 68 or 96 per cent of the days had recorded water temperatures that exceeded 49 degrees Celsius.

A review of the home's policy titled "Water Temperature Monitoring" last revised December 27, 2016, indicated that once notified of hot water temperature issues, the MPS was to take immediate actions to remedy the situation. All resident home areas were to be advised of either high or low water temperatures that were expected for more than 15 minutes and appropriate measures were to be taken to rectify the situation and ensure resident safety.

During an interview with Inspector #609, Maintenance Worker #110 indicated that when water temperatures were recorded that exceeded 49 degrees Celsius, a phone call or email was sent to the MPS outlining the water temperature concerns. Maintenance Worker #110 was unable to describe what immediate measures were to be taken to rectify the water temperature exceeding 49 degrees Celsius or how they would be able to know when the temperature was expected to be out of range for longer than 15 minutes.

During an interview with Inspector #609, RPN #109 verified that maintenance staff checked water temperatures often but had never been given direction or what to do when the temperature exceeded 49 degrees Celsius to ensure resident safety.

During an interview with RPN #111 verified that maintenance staff checked water temperatures on the unit but had never been given any directions or measures to ensure resident safety when the water temperature exceeded 49 degrees Celsius.

During an interview with the Administrator and MPS, a review of the domestic water temperature record was conducted and both acknowledged recorded values exceeding 49 degrees Celsius. The MPS indicated that when a value exceeding 49 degrees Celsius was recorded by maintenance staff they were to continue on with the monitoring to establish if other areas of the home were experiencing the same concern. The MPS was unable to provide any record of any actions taken to

immediately reduce the water temperature when found to exceed 49 degrees Celsius, to ensure resident safety. (609)

3. The licensee has failed to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

On a particular day, Inspector #609 took the temperature of the water in the hand basin in room 122 on Killarney unit at 1130 hours, and found it to be 32.7 degrees Celsius.

On a particular day, the water temperature in the Pine unit tub room at 1020 hours was 39 degrees Celsius while the shower in Pine unit was found to be 36.1 degrees Celsius which were verified at the time of recording with HCA #114. At 1450 hours the York unit tub room hand basin was 37.7 while the hand basin in York unit room 119 was 31.1 degrees Celsius at 1455 hours.

During an interview with the Inspector, HCA #114 indicated that low water temperatures had been an ongoing issue. HCA #114 was unable to describe any measures to be taken when water temperatures were lower than 40 degrees Celsius and went on to state that baths were still provided to residents the week previously when the tub water temperature only reached 34 degrees Celsius.

During an interview with resident #007 on a particular day, they described that for at least the past four weeks the water temperature for bathing had been cool.

During an interview with resident #008 on a particular day, they described how between 1000 and 1100 hours daily, the water was cold.

During an interview with resident #009 on a particular day, they stated that two weeks previously the water was so cold in the tub room that they were unable to have a bath and were instead given a sponge bath in bed.

A review of the home's daily domestic water temperature monitoring records between October 31, 2016, and January 9, 2017, found that the water temperature on December 18, 2016, for a specific unit was 37.1 degrees Celsius, on December

28, 2016, 38.3 degrees Celsius and 38.5 degrees Celsius on January 3, 2017.

A review of the shift to shift "Daily Report- Resident Care" for an identified unit during a one week period in January 2017 found that on two days hot water was unavailable for baths after 1000 hours. The report also indicated that resident #016 missed their bath as a result of no available hot water on one of the days.

A review of the plan of care for resident #016 indicated that they preferred a bath.

A review of the Point of Care (POC) documentation for resident #016 on the specified day, indicated that the resident was provided a bed bath.

A review of the home's policy titled "Water Temperature Monitoring" last revised December 27, 2016, indicated that hot water serving all bathtubs, showers and hand basins used by residents shall range between 40-49 degrees Celsius.

During an interview with the MPS, they acknowledged fluctuations in the home's water temperatures that were below 40 degrees Celsius and that this was an ongoing issue.

The scope of this issue was determined to have been widespread domestic water temperatures below 40 degrees or exceeding 49 degrees Celsius. There was a previous CO issued related to this provision during inspection #2016_269627_0011 on September 27, 2016. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents provided domestic water below 40 degrees or exceeding 49 degrees Celsius, especially when the home does not take immediate action to correct out of range water temperatures. (609)

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

Aug 31, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_320612_0010, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall:

a) Ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

b) Ensure that regardless of the staffing level of the home all residents are provided their scheduled baths in their preferred method.

c) Ensure that if a resident is not provided with their scheduled bath or in their preferred method, that a process is developed and implemented to expeditiously ensure that residents are offered and provided with a second bath of their preferred method.

d) Ensure that if a resident is provided with a complete bed bath, that staff provide the bed bath as instructed the home's policy titled "Personal Care-Bathing: Complete, Partial, Tub Bath, or Shower".

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A previous CO was issued on May 24, 2016, to address the licensee's failure to comply with s.31 (3) of O.Reg. 79/10 during Follow Up Inspection #2016_320612_0010(A1).

The CO required the licensee to; ensure that their staffing mix was evaluated and updated to ensure that the residents' care and safety needs were met; that all residents received their preferred and scheduled bath as identified in their plan of care and; that a record was kept of the evaluation including who participated in the review, the date of the review, the changes made and the date the changes were implemented.

Full compliance of the CO was expected by June 14, 2016.

A) A review of the home's shift to shift reports was conducted by Inspector #609 for a two week period between December 2016 and January 2017 which found that seven of the 14 days or 50 per cent of the time, during the two week period, between one to

six residents on a unit had not received their preferred or scheduled bath.

A further review of the home's HCA schedule was conducted with Scheduler #122 for specified days between December 2016 and January 2017 which found that where residents' preferred or scheduled baths were not provided, every unit had been short HCA staff of between 2.5 to 7.5 hours during a single shift.

A review of health care records found that the HCA staff shortages on particular days impacted residents as follows:

-Park Place unit was short one full afternoon shift which resulted in resident #019, #020 and #021 not receiving a tub bath as per their plans of care;

-Park Place unit was short one full afternoon shift which resulted in resident #022, #023, #024, #025 not receiving a tub bath as per their plans of care;

-Cranberry unit was short a partial day shift which resulted in resident #026 not receiving a shower as per their plan of care;

-Cranberry unit was under staffed using a modified worker in the afternoon who was unable to perform HCA duties which resulted in resident #027, #028, #029, #030, #031 not receiving a shower or tub bath as per their plans of care;

-Cranberry unit was short half an afternoon shift which resulted in resident #032, #033, #034 not receiving their tub baths as per their plans of care. Lilac-Mallard (LM) unit was short a partial day shift and half an afternoon shift which resulted in resident #036, #037, #038 not receiving a tub bath as per their plans of care;

-Park Place unit was short half an afternoon shift which resulted in resident #020, #021, #023, #039, #040 not receiving a tub bath as per their plans of care. Pine unit was short one full day shift which resulted in resident #041, #042 not receiving a tub bath as per their plans of care and;

-Pine unit was short a full day shift which resulted in resident #043, #044, #045 not receiving a tub bath as per their plans of care.

B) During an interview with HCA #119, they verified that they were present and working on a particular day on one of the units which was short one full HCA shift.

They went on to describe that when short of staff as they were on the particular day, the preferred and scheduled showers or tub baths were not performed and that a complete bed bath was to be provided for the resident's scheduled bath.

A review of the home's policy titled "Personal Care- Bathing: Complete, Partial, Tub Bath, or Shower" last revised December 21, 2015, indicated that when working at minimum staffing levels in a unit, staff were expected to provide all residents care as per their plans of care and if unable to provide a resident with their bath of choice, the resident was to be offered a complete bed bath and hair wash in bed. The policy further indicated that bed bathing also included foot care and cleaning and trimming of fingernails and toenails.

During an interview with HCA #123, they verified that they were present and working on a specific unit on a particular day, which was short a full afternoon shift. They further verified that they documented resident #029 as a complete bath yet sponged the resident as they sat on the toilet.

During an interview with Scheduler #124, they indicated that another specific unit was short a full day shift HCA as well as a full afternoon shift HCA on a particular day.

A review of the shift to shift report for the specified unit on the particular day, indicated that no baths were given that day related to shortages of staff.

During an interview with resident #048, they verified that they had not received a tub bath as per their plan of care on the particular day. They further described that they were assisted to lightly sponge bath at the sink in their room and that the care was not provided in bed.

During an interview with RPN #129, they indicated that when short of HCA staff and baths could not be completed, the more independent residents like resident #048 would be sponge bathed at the sink.

A review of resident #047's plan of care indicated that on a particular day, the resident was to have received a complete bed bath which included nail care and trimming, yet observations next day of resident #047 noted the resident had long, untrimmed fingernails with dark crusted debris underneath.

A review of resident #047's health care records found that on the particular day, the HCA documented "not applicable" for the required nail care.

During an interview with the Manager of Resident Care (MRC), they verified that when short of HCA staff a complete bed bath was to be provided to the residents, defined as thorough cleanse in the resident's bed which included hair and nail care. The MRC indicated that over the next month education would be provided to staff as to what was expected when giving a complete bed bath and that sponging residents at the sink would not qualify as a complete bed bath.

C) The home provided a document which tabulated a quarterly percentage of how many residents received their preferred and scheduled baths titled "Bath Audits". A review of the home's "Bath Audits" found that between 14 and 18 per cent of residents' preferred baths over the last two quarters in 2016 were not provided due to shortages of staff.

A review of the home's policy titled "Personal Care- Bathing : Complete, Partial, Tub Bath, or Shower" last revised December 21, 2015, indicated that each resident was to be offered a bath at a minimum, twice a week by a method of his or her choice.

During an interview with the MRC, a review of the home's "Bath Audits" was conducted. The MRC verified that it was the goal of the home that each resident was provided with a minimum of two baths of their choosing per week. The MRC acknowledged that with an average of 18 per cent of residents not provided with their chosen baths during the 2016 year related to staffing shortages, the home still had improvements to make.

D) During an interview with the MRC, they indicated that the home's working short of staff contingency plan was updated in August 2016.

During the same interview with the MRC, the home's "Resident Care Section Staffing Contingency Plan" last revised August 9, 2016 was reviewed which indicated that anytime there were seven residents in the home who had not received a bath of their choice due to a unit working below the minimum staffing level, the night RN would send out a request for additional staff (staff stat) between 0530 and 0600 hours requesting a HCA work 0900 to 1700 hours the next day to provide those residents a bath.

A review of the home's shift to shift reports was conducted for a two week period between December 2016 and January 2017 which found that on a particular day, a total of eight residents did not receive a bath related to HCA staff shortages.

During an interview with the MRC, they indicated that the RN on night shift, did not follow the home's contingency plan and as a result did not call in additional HCA staff to make up the missed baths. The MRC acknowledged that additional training was required to ensure that the night RNs call in additional staff when seven or more residents did not receive a bath of their choice during a single day.

The scope of this issue was determined to have been a pattern of the staffing plan not providing for a staffing mix that was consistent with residents' assessed care and safety needs. There was a previous CO issued to the home related to this provision during RQI inspection #2015_391603_0029 on January 8, 2016, and a second CO reissued during follow up inspection #2016-320612-0010(A1) on May 24, 2016. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents not provided with a staffing mix that was consistent with their assessed care and safety needs. (609)

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

Apr 12, 2017

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant:

2016_320612_0010, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall:

a) Ensure that all residents of the home are not neglected by the licensee or staff.

b) Ensure that when a resident exhibits a significant change in their status, that staff act promptly and comprehensively to address the resident's health, safety and well being.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the license or staff.

A previous CO was issued on May 3, 2016, to address the licensee's failure to comply with s. 19.(1) of the LTCHA, 2007, during Follow Up Inspection #2016_320612_0010(A1).

The CO required the licensee to: retrain all staff related to the home's abuse policy and; keep a written record of the retraining.

Full compliance of the CO was expected by September 6, 2016.

Upon Follow Up inspection, while the home completed all the required retraining, a concurrent Complaint inspection #2017_613609_0003 was performed which found the following non-compliance:

The Long-Term Care Homes (LTCH) Act, 2007 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being" and includes inaction or a pattern of inaction that

jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to Director which alleged that resident #006 was not well on a particular day and exhibited specific symptoms. The complainant further indicated that the resident's health status deteriorated, was transferred to the hospital and diagnosed with a specified illness.

A review of physician #134's hospital report indicated that resident #006 had a specified illness.

Inspector #627 reviewed resident #006's plan of care for the week prior to the resident's hospital admission which indicated that they needed an identified level of care from staff.

A review of resident #006's progress notes during a one week period prior to their transfer to hospital, established a timeline of the resident's progressive deterioration. On a particular day the resident was noted to be exhibiting symptoms. The initial entry was followed by 20 additional progress notes documenting the resident's continued symptoms which resulted in the resident being transferred to the hospital on a particular cay.

A review of the home's policy titled "Case Definition For Urinary Tract Infections", last revised December 15, 2013, indicated a resident may have a symptomatic urinary tract infection if at least three of the following signs and symptoms were present: Fever, new or increasing burning pain on urination, frequency, urgency, new flank or suprapubic pain or tenderness, change in character of urine, worsening of mental or functional status, for example decreased appetite, falls, change in sleep pattern, behavior changes, agitation or drowsiness.

A review of the home's policy titled, "Vital Signs: Temperature, Pulse, Respiration, Blood Pressure and Pain" last revised July 28, 2016, indicated that residents were to have their vitals assessed by qualified staff on a routine basis and in case of a change in their conditions.

A review of the home's policy titled "Physician Group Medical Directives" issued March 17, 2008, indicated that urine for culture and sensitivity (C&S) was to be collected if symptoms indicated.

A review of resident #006's health care records found no head to toe assessments, no documented temperature and no specific lab testing prior to the resident's hospitalization.

A review of the home's physician communication binder found entries on four particular days, indicating that resident #006 was symptomatic. There was no further entries to communicate the resident's ongoing and increasing symptoms.

During an interview with resident #006's family member they stated that the resident "did not look well", the week prior to their hospital admission. When they came to visit, they found the resident "looked like they were dying". They then called the SDM and advised them of their concerns and that the SDM should call physician #136 immediately.

During an interview with resident #006's SDM they stated prior to the hospital admission, resident #006 had told them and stated they did not feel well. The SDM stated that they called the home on a particular day, and spoke to physician #136 who stated that resident #006 seemed to have improved. Two days later the SDM received a call from a family member who had visited with resident #006. The family member informed the SDM that the resident was not looking well and that they should call the physician to discuss. The SDM stated that they had followed up with the home two days later and had spoken to a nurse who stated that they would make the physician aware of their concerns and that they were monitoring the resident very closely. Two days after that the SDM called the home and spoke with an RN who told the SDM that the resident "looked like they were on their death bed". The SDM stated that they had called physician #136 and insisted that the resident be sent to the hospital.

During an interview with RPN #109 they stated that when a resident presented with a significant change, an assessment was to be done including vital signs which would include the resident's temperature, other symptoms, and level of consciousness. RPN #109 stated that resident #006 was difficult to assess and often demonstrated behaviours and was difficult to determine if the resident was ill or if they were demonstrating behaviours. RPN #109 further stated that they had not completed a head to toe assessment of the resident. RPN #109 stated that they had not inquired about other symptoms. They also stated that a specific lab test should have been completed as many residents presenting with similar symptoms had an infection. RPN #109 stated that the staff had been negligent as they had focused on

behaviours and not on a full physical assessment of the resident's decline.

During an interview with RN #123 they stated that when a resident has a significant change, the resident would be monitored by the RN supervisor and that appropriate actions were to be taken. RN #123 further stated that for resident #006, a specific lab test should have been completed and the physician should have been called to assess as the resident's condition further deteriorated. Vital signs should have been closely monitored on every shift, which would have included taking the resident's temperature. RN #123 stated that this was a situation of treating the resident's deterioration as behavioural and indicated that the staff had been negligent.

During an interview with PC #125 they stated that when a resident had a significant change in condition (as in the case of resident #006) a head to toe assessment was to be completed by a registered staff member, and abnormal findings were to be followed up on with appropriate action. They further stated that resident #006 had appeared very ill in the last few days and that in hindsight, the focus should have been on a comprehensive medical assessment instead of concentrating on the resident's behaviour.

The scope of this issue was determined to have been isolated to one neglected resident. There was a previous CO issued to the home related to this provision during RQI inspection #2015_391603_0029 on January 8, 2016, and a second CO reissued during follow up inspection #2016-320612-0010(A1) on May 24, 2016. The severity was determined to have been actual harm occurred to the health, safety and well-being of resident #006 whose health deterioration was not acted upon by staff and resulted in the resident being transferred to the hospital. (609)

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

Apr 26, 2017

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 004

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

Linked to Existing Order / Lien vers ordre existant: 2016_320612_0010, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall:

a) Ensure that all staff of the home comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.

b) Specifically ensure that a process is developed and implemented to monitor and evaluate HCA #131's day by day performance to ensure they comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A previous Compliance Order (CO) #003 was issued on May 24, 2016, to address the licensee's failure to comply with s. 20. (1) of the LTCHA, 2007 during Follow Up Inspection #2016_320612_0010(A1).

The CO required the licensee to ensure that: all required staff completed retraining on the home's "Promoting Zero Tolerance of Abuse and Neglect of Residents" policy and; that a written record was kept of the retraining which included who participated

in the retraining, when it occurred and what it entailed.

Full compliance with the CO was expected by September 6, 2016.

Upon Follow Up inspection, while the home completed all the required retraining, a concurrent Critical Incident inspection #2017_613609_0002 was performed which found the following non-compliances.

1) A Critical Incident report was submitted to the Director, which outlined allegations of verbal and emotional abuse that occurred on a particular day by HCA #131 toward residents #050 and #051.

Inspector #609 reviewed the home's internal investigation which found that a resident observed HCA #131 dress resident #050 in pajamas to attend the dinner, told the resident that they would not assist them with certain care needs more than once that evening and after dinner placed the resident in bed at 1830 hours. Resident #050 was found by the other resident to be upset after the incident. Resident #050's plan of care directed staff to provide certain assistance as needed as well as assist the resident to bed at a time much later than was provided.

A review of the home's interview with resident #050 found that the resident had not wanted to go to bed at 1830 hours but HCA #131 advised the resident they would not provide certain care.

The home's internal investigation also found that during the same afternoon shift resident #051 had complained of difficulties with their special treatment and requested the assistance of HCA #131, who argued with the resident that there was no issues with the treatment. HCA #131 further denied resident #051 certain assistance before dinner.

A review of the home's interview with HCA #133 verified they were present and observed HCA #131 argue with resident #051 about their treatment difficulties the resident was experiencing as well as their refusal to assist the resident with certain care before dinner.

The Long-Term Care Homes (LTCH) Act, 2007 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of

acknowledgement or infantilization that is performed by anyone other than a resident.

The LTCH Act also defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that are made by anyone other than a resident.

During interviews with resident #050 and #051, they both verified that HCA #131 acted abusively towards them and did not want HCA #131 caring for them anymore.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" last revised February 4, 2016, indicated that residents would be free from abuse by staff.

During an interview with the MRC, they verified that HCA #131 did not comply with the home's abuse policy and received disciplinary action.

2) A CI report was submitted to the Director alleging staff to resident abuse. It was alleged that HCA #128 provided care to resident #035 in a rough and neglectful manner.

Inspector #627 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect", last revised February 4, 2016, which defined neglect as failing to provide a resident with treatment, care, services or assistance to ensure their health, safety or well-being.

The Long-Term Care Homes (LTCH) Act, 2007 further defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During an interview with the Inspector, resident #035's family member stated that they were at the home on a particular day. The following concerns were expressed regarding the care provided to resident #035 by HCA #128:

-HCA #128 brought the resident back to their room and asked the family member to dress resident #035 in their pajamas;

-HCA #128 was going to transfer the resident unsafely, at which time the family member informed them that this was not as per the resident's plan of care;

-HCA #128 grabbed the resident by their clothing to roll them over and used poor technique to provide care to the resident. The HCA then used unsafe and improper technique to move resident #035 which caused the resident to scream in pain and shed tears.The HCA then left for 20 minutes;

-While HCA #128 was gone, the resident soiled themselves and the family member had to assist the resident to cleanse. HCA #128 returned without assisting the resident and then left for another 15 minutes;

-Upon return, HCA #128, once again caused pain to the resident by using improper transfer technique. The HCA then left for the third time, leaving the resident completely uncovered. The family member questioned them, the HCA grabbed the blankets and tossed them up which covered the resident's face. Only after the family member questioned how the blankets were left did they uncover the resident's face and;

-While HCA #128 was in resident #035's room they rudely spoke to the family member that was present and left for an additional 30 minutes.

A review of a letter as part of the internal investigation, found that HCA #128 did not review resident #035's plan of care prior to providing services, appeared to have abandoned the resident for excessive times and "While they insist that they did not behave in an abusive manner it would seem the facts point to a different conclusion. Neglecting to care for the resident was, in itself, an abuse and it was unacceptable". HCA #128 was subsequently terminated.

During an interview with Inspector #609, the MRC verified that HCA #128 did not comply with the home's policy titled "Abuse: Resident Abuse/Neglect", last revised February 4, 2016.

The scope of this issue was determined to have been isolated to two incidents of staff not complying with the home's zero tolerance of abuse and neglect policy. There was a previous CO issued to the home related to this provision during RQI inspection #2015_391603_0029 on January 8, 2016, and a second CO reissued during follow up inspection #2016-320612-0010(A1) on May 24, 2016. The severity

was determined to have been actual harm occurred to the health, safety and well-being of residents abused by staff in the home. (609)

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

Mar 22, 2017

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
Long-Term Care Inspections 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

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

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 23 day of June 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : - (A1)

Service Area Office /
Bureau régional de services : Sudbury