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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2017	2017_657681_0004	008836-17, 012847-17	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

STEPHANIE DONI (681)

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): July 24-28, 2017 and July 31-August 1, 2017.

The following intakes were completed in this Critical Incident System (CIS) inspection:
- One intake related to staff to resident abuse.
- One intake related to a fall resulting in a fracture.

A Complaint inspection #2017_657681_0005 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Manager of Resident Care, Program Coordinators, Resident-Assessment-Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Health Care Aides (HCA), Nutritional Aides (NA), and residents.

The inspector also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

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.
3 WN(s)
1 VPC(s)
0 CO(s)
1 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. 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.

The Ontario Regulation 79/10 (O. Reg. 79/10) 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 are performed by anyone other than a resident.

A Critical Incident Systems (CIS) report was submitted to the Director about alleged staff to resident abuse that involved multiple staff members and multiple residents. The CIS report indicated that staff members used a device to take and share pictures or videos of residents, and that some of these images were of an inappropriate nature.

Inspector #681 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect" last updated March 21, 2017, which indicated that resident abuse will not be tolerated and that anyone who witnesses, or becomes aware of or suspects resident abuse must report the incident immediately to the Registered Staff/immediate Supervisor who will then report it to the appropriate Manager for further investigation.

The Inspector reviewed the home's investigation notes, which identified that on a particular day, HCA #103 witnessed HCA #102 take an inappropriate picture of resident #002. On the same day, the home's investigation notes indicated that HCA #102 showed RPN #104 a device, which contained an inappropriate picture of a resident. Attached to the picture was an audio clip of a degrading nature. RPN #104 did not report what they had observed to the Acting Manager of Resident Care until five days after the incident occurred.

The home's investigation notes also indicated that HCA #102 admitted to taking the picture of resident #002. HCA #102 was subsequently terminated because of the incident.

In an interview with the Inspector, HCA #103 stated that they did not report what they had witnessed because they were fearful of HCA #102.

In an interview with the Inspector, RPN #104 also stated that they did not immediately report the incident because HCA #102 could be quite aggressive and intimidating.

In an interview with the Inspector, the Acting Manger of Resident Care verified that there was a picture of resident #002 taken by HCA #102. The picture was witnessed being

taken by HCA #103 and later shown to RPN #104. However, the incident was not reported to the home until five days after it had occurred. [s. 20. (1)]

2. During the review of the home's investigation notes related to HCA#102 taking inappropriate photos of resident #002, the Inspector reviewed secondary incidents involving HCA #102 and residents #009 and #003.

The home's policy titled "Abuse: Resident Abuse/Neglect" last updated March 21, 2017, indicated resident abuse will not be tolerated and that residents will be free from abuse by employees, students, volunteers, service providers, visitors and other residents.

The home's investigation notes indicated that HCA #102 took an inappropriate video of the resident #009 and shared it through a mobile application (app) that allows users to take and share pictures and videos that can be altered using filters and that self-delete after being viewed.

The home's investigation notes also indicated that HCA #102 admitted to taking pictures of resident #003 and used the mobile app filters to alter these images. HCA #102 was subsequently terminated because of their actions.

In an interview with the Inspector, the Acting Manger of Resident Care verified that an inappropriate video of resident #009 and pictures of resident #003 were taken by HCA #102. [s. 20. (1)]

3. The home's investigation notes indicated that RPN #105 admitted to taking an inappropriate video of resident #001. A mobile app filter was added to alter this video and the video was shared through the mobile app. RPN #105 was subsequently terminated for their actions.

In an interview with the Inspector, the Acting Manger of Resident Care verified that a video of resident #001 was taken by RPN #105 and that mobile app filters were used on this video. [s. 20. (1)]

4. The home's investigation notes indicated that HCA #106 took pictures or videos of resident #005, resident #006, resident #007, and resident #008. Mobile app filters were used to alter the images and the pictures or videos were then shared through the mobile app. HCA #106 was subsequently terminated because of their actions.

In an interview with the Inspector, the Acting Manger of Resident Care verified that pictures or videos were taken by HCA #106 of resident #005, resident #006, resident #007, and resident #008 and that mobile app filters were used to alter these images.

A Compliance Order (CO) was issued to the licensee on July 31, 2017, to address failure to comply with s. 20. (1) of the LTCHA, 2007 during RQI Inspection #2017_616542_0010. The compliance due date of this CO was August 18, 2017. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Ontario Regulation 79/10 (O. Reg. 79/10) 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 are performed by anyone other than a resident.

Inspector #681 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect" last updated March 21, 2017, which indicated that the Program Coordinator for the resident home area was responsible for immediately initiating an on-line Critical Incident System form for all instances of alleged abuse or, if after normal business hours, contacting the after hours pager number and ensuring that a Critical Incident form was completed on the next business day.

A Critical Incident System (CIS) report was submitted to the Director about alleged staff to resident abuse that involved multiple staff members and multiple residents. The CIS report indicated that staff members used a device to take and share pictures or videos of residents and that some of these pictures were of an inappropriate nature.

On a particular date, RPN #104 advised the Acting Manager of Resident Care that an inappropriate picture had been taken of a resident. Attached to the picture was an audio clip of a degrading nature. On the same day, HCA #102 was suspended with pay pending the outcome of the investigation. The home initiated their investigation on the next business day. Notification of this critical incident was not received by the Director until six days after it had been reported to the Acting Manager of Resident Care.

In an interview with the Inspector, the Acting Manager of Resident Care verified that they had been made aware of this incident, but that the Director was not notified until six days later once the home's investigation had been completed. The Acting Manager of Resident Care stated that the delay in reporting to the Director was because the home initially believed the incident to be a breach of privacy and confidentiality and not abuse. [s. 24. (1)]

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 when the home has reasonable grounds to suspect that abuse of a resident by anyone has occurred that this suspicion and the information upon which it is based be immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's documented record of complaints were reviewed and analyzed for trends at least quarterly and that the results of this review were taken into account when determining what improvements were required in the home.

During the course of the inspection, an employee of the home advised the Inspector that they had submitted an anonymous complaint to the home. The Inspector requested to see the home's complaint log. The Inspector was advised by the home's Administrator that the Program Coordinator or Manager responsible for the home area where the complaint originated would be responsible for investigating and responding to the complaint. Each Program Coordinator or Manager would subsequently be responsible for maintaining and storing documentation related to their complaint investigation.

During separate interviews with the Inspector, Program Coordinator #101 and #111 reported that they stored all documentation related to complaints electronically. Program Coordinator #101 stated that they also emailed a copy of all complaints to the Manager of Resident Care and stored a copy in a specific location so that it could be accessed in their absence. Program Coordinator #111 indicated that a copy of the complaint was sent via email to the home's Administrator. Both Program Coordinator #101 and #111 stated that they were uncertain or unaware about how the home reviewed and analyzed complaint trends.

In an interview with the Inspector, the Acting Manager of Resident Care stated that they were not aware of a process for reviewing complaints and analyzing complaint trends.

The home's policy titled "Complaints and Reporting Requirements" last revised February 15, 2017, stated that all complaints were to be tracked in a specific Complaint Resolution folder for compliancy. The policy indicated that once the complaint had been resolved the Administrative Assistant was to complete the complaint log and provide the Administrator with a quarterly report.

During an interview with the Inspector, Administrative Assistant #113 stated that there was only one complaint included in the Complaint Resolution folder and that this was a verbal complaint related to missed baths.

In an interview with the Inspector, the Administrator verified that the home had not been tracking complaints as per the "Complaints and Reporting Requirements" policy nor had the complaints been reviewed on a quarterly basis to identify trends. [s. 101. (3)]

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Issued on this 29th day of August, 2017

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

Original report signed by the inspector.