



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**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

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| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|--|----------------------------------|--|
| Nov 29, 2017; | 2017_657681_0006 (A1) | 020861-17 | 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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #001 amended to reflect a compliance due date of December 8, 2017.



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Issued on this 29 day of November 2017 (A1)

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

Original report signed by the inspector.



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

STEPHANIE DONI (681) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié



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

This inspection was conducted on the following date(s): September 11 - 12, 2017. Additional off-site inspection activities were completed on September 13 - 14, 2017, and October 5, 2017.

This Critical Incident System (CIS) inspection is related to a critical incident that the home submitted regarding allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Acting Manager of Resident Care, Registered Practical Nurses (RPNs), and Health Care Aides (HCAs).

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:

Critical Incident Response

Prevention of Abuse, Neglect and Retaliation



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

- 1 WN(s)
- 0 VPC(s)
- 1 CO(s)
- 0 DR(s)
- 0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|--|
| <p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p> | <p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p> |
| <p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

WN #1: The Licensee has failed to comply with LTCHA, 2007, 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 financial abuse as any misappropriation or misuse of a resident's money or property.

A Critical Incident System (CIS) Report was submitted to the Director about a circulated document that included an allegation of staff to resident financial abuse.

The Inspector reviewed the employee file for Laundry Worker #104. The employee file included a letter of termination, which indicated that, on a particular day, management met with Laundry Worker #104 to discuss concerns raised by a resident's family member.

In an interview with the Inspector on September 12, 2017, Manager of Resident Care #101 stated that the incident referred to in the termination letter involved a complaint made by a family member of resident #002. Resident #002's family member had advised the home's Administrator that they identified potential concerns when they were going through resident #002's banking records.

The Inspector reviewed all of the submissions made through the Ministry of Health and Long-Term Care's online CI reporting system during a specified time period. No CIS Report was submitted by the home about misappropriation of a resident #002's funds during this particular time period.

During a telephone interview with the Inspector on September 14, 2017, Manager of Resident Care #101 stated that a CIS Report had not been submitted to the Director about the incident. Manager of Resident Care #101 stated that a CIS report had not been submitted because, at the time, the home did not feel the incident constituted financial abuse for the following reasons:

- 1) The home was unable prove misappropriation of resident #002's funds.
- 2) The family of resident #002 did not want a formal complaint pursued.
- 3) Laundry Worker #104 was not a direct care provider. [s. 24. (1)]



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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



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

Original report signed by the inspector.



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Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the Long-Term
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2007, c. 8

Aux termes de l'article 153 et/ou de
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O. 2007, chap. 8

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Name of Inspector (ID #) /

Nom de l'inspecteur (No) : STEPHANIE DONI (681) - (A1)

Inspection No. /

No de l'inspection : 2017_657681_0006 (A1)

Appeal/Dir# /

Appel/Dir#:

Log No. /

No de registre : 020861-17 (A1)

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Nov 29, 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 : Aaron Archibald



Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the Long-Term
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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) |
|-------------------------------------|--|

Pursuant to / Aux termes de :

LTCHA, 2007, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

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 financial abuse as any misappropriation or misuse of a resident's money or property.



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O. 2007, chap. 8

A Critical Incident System (CIS) Report was submitted to the Director about a circulated document that included an allegation of staff to resident financial abuse.

The Inspector reviewed the employee file for Laundry Worker #104. The employee file included a letter of termination, which indicated that, on a particular day, management met with Laundry Worker #104 to discuss concerns raised by a resident's family member.

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- 1) The home was unable prove misappropriation of resident #002's funds.
- 2) The family of resident #002 did not want a formal complaint pursued.
- 3) Laundry Worker #104 was not a direct care provider. [s. 24. (1)]

During previous inspections (#2015_282543_0018, #2015_391603_0029, #2016_336620_0004 and #2017_657681_0004) Written Notifications (WN) were issued to the home on September 18, 2015, and February 11, 2016, respectively, a Compliance Order (CO) was served to the home on January 8, 2016, and a Voluntary Plan of Correction (VPC) was issued to the home on August 21, 2017. The decision to issue a compliance order was based on the severity, which indicated potential risk of actual harm to the residents of the home. Furthermore, the home's compliance history identified ongoing non-compliance related to this section, which included one CO, one VPC and two WNs previously issued within the past 36 months. (681)



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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

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

Dec 08, 2017(A1)



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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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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



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section 154 of the Long-Term
Care Homes Act, 2007, S.O.
2007, c. 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

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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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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



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foyers de soins de longue durée, L.
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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29 day of November 2017 (A1)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

STEPHANIE DONI



**Ministry of Health and
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**Service Area Office /
Bureau régional de services :**

Sudbury