Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2018	2018_435621_0007	027292-17, 027293-17, 000191-18, 002859-18, 003374-18, 003897-18	Critical Incident System

Licensee/Titulaire de permis

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

JULIE KUORIKOSKI (621), AMY GEAUVREAU (642), KATHERINE BARCA (625)

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): February 26 - March 2, 2018, and March 5 - 9, 2018.

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

Complaint inspection #2018_435621_0006, Other inspection #2018_624196_0006 and Follow Up inspection #2018_435621_0008 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care (MORC), Program Coordinators, the Scheduler, Registered Nurses (RNs), and Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The Inspectors also reviewed resident care records, policies and procedures, investigation files, relevant employee records, staff schedules, training records and observed 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.
2 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who had received training under s.76, subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

According to O.Reg 79/10 s.219 (1), the intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

During review of a Critical Incident (CI) report submitted to the Director related to an incident of alleged staff to resident abuse, Inspector #625 identified that PSW #117 had not received training on the homes' abuse and neglect policy. Additionally, it was determined that PSW #117 was an agency staff member from the Plan A Staffing Agency.

As identified in the LTCHA 2007, c.8, s. 2(1), the definition of "staff" is: in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

Inspector #196 reviewed the home's Plan A staffing schedule as provided by Program Coordinator #115, which identified a specific number of Plan A agency PSWs had worked scheduled shifts in the home over a specified period of time.

During an interview with Scheduling Clerk #123, they confirmed to Inspector #196 that the Plan A agency PSWs had worked in the home a specific number of shifts over a specified period of time.

During an interview, the Manager of Resident Care (MORC) reported to Inspector #625 that the Plan A agency PSWs had not received annual retraining for a specific time period. In addition, the MORC reported that all Plan A agency PSWs working in the home at the time of inspection had not been trained on the homes' current abuse and neglect policy. [s. 76. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

Inspector #625 reviewed a Critical Incident System (CIS) report submitted to the Director for a specified number of incidents of staff to resident neglect that occurred on a specific shift on a day in August 2017. The report identified that:
- PSW #119 observed PSW #118 leave resident #005 in a specific location in a specific condition, and RPN #120 had to intervene to ask PSW #118 complete a certain task with the resident;
- RPN #120 observed resident #004 at a certain time and asked PSWs #117 and #118 to attend to the resident. It was identified in the report that the PSWs did not attend to the resident as requested, and the RPN had to ask the same PSWs a second time to attend to the resident and complete the task. Further, RPN #120 identified that resident #004 was not assisted until a specified time; and
- PSW #119 observed resident #006 during a specific incident and asked PSW #118 for assistance which was not provided until the request had been repeated by PSW #119 a specific number of times. Additionally, PSW #118 was reported to have failed to notify RPN #120 of resident #006's incident.

During an interview with Inspector #625, PSW #119 and RPN #120 corroborated details they had witnessed, as identified in the CIS report. Additionally, RPN #120 confirmed that

they had not contacted RN #121 when they became aware of any of the specific number of incidents which occurred during the specified shift, but waited until a later specified time, to inform the RN.

A review of the home's "Abuse: Resident Abuse/Neglect" policy, last revised July 11, 2017, in place at the time of the incident, identified:
- neglect was defined as “failing to provide a resident with treatment, care, services or assistance required for health, safety or well-being. Note can include inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents”;
- anyone who witnessed, or became aware of, or suspected resident abuse, was required to report the incident immediately to the Registered Staff who would then report it to the appropriate Manager for further investigation.

During an interview with Inspector #625, Program Coordinator #115 stated that, during a specific shift, PSW #118 was found to have neglected residents #004, #005 and #006 as detailed in the CIS report. Program Coordinator #115 also stated that PSW #119 and/or RPN #120 were aware of the incidents at the times that they occurred, but neither of them reported the neglect to RN #121 as was required, until the RN attended the home area at a specified time.

The home previously had Compliance Order #001 issued from Resident Quality Inspection #2017_616542_0010 for s.20(1) with a compliance due date of August 18, 2017. A Written Notification (WN) was issued for the incident identified within this report, as the incident occurred prior to the compliance order due date. [s. 20. (1)]

Issued on this 13th day of March, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621), AMY GEAUVREAU (642), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2018_435621_0007
Log No. / No de registre :	027292-17, 027293-17, 000191-18, 002859-18, 003374-18, 003897-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 13, 2018
Licensee / Titulaire de permis :	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

To City of Greater Sudbury, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee must be compliant with s.76(4) of the LTCHA.

Specifically, the licensee must:

a) Ensure that all agency staff are retrained on the homes' current abuse and neglect policy, and subsequent retraining occurs annually.

b) Ensure that records of retraining on the homes' current abuse and neglect policy are maintained in the home, including when each agency staff completed the retraining, and what the retraining entailed.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the persons who had received training under s.76, subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

According to O.Reg 79/10 s.219 (1), the intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

During review of a Critical Incident (CI) report submitted to the Director related to an incident of alleged staff to resident abuse, Inspector #625 identified that PSW #117 had not received training on the homes' abuse and neglect policy. Additionally, it was determined that PSW #117 was an agency staff member from the Plan A Staffing Agency.

As identified in the LTCHA 2007, c.8, s. 2(1), the definition of "staff" is: in relation

to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

Inspector #196 reviewed the home's Plan A staffing schedule as provided by Program Coordinator #115, which identified a specific number of Plan A agency PSWs had worked scheduled shifts in the home over a specified period of time.

During an interview with Scheduling Clerk #123, they confirmed to Inspector #196 that the Plan A agency PSWs had worked in the home a specific number of shifts over a specified period of time.

During an interview, the Manager of Resident Care (MORC) reported to Inspector #625 that the Plan A agency PSWs had not received annual retraining for a specific time period. In addition, the MORC reported that all Plan A agency PSWs working in the home at the time of inspection had not been trained on the homes' current abuse and neglect policy.

The severity of this issue was determine to be a level 1 as there was potential for harm. The scope of the issue was a level 3 as all Plan A agency PSWs had not been retrained on the home's updated abuse and neglect policy. The home had a level 2 history with unrelated non-compliance within the previous three years. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 13, 2018

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

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 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

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 13th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Julie Kuorikoski

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