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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 5, 2019	2019_752627_0005	003979-19	Resident Quality Inspection

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

SYLVIE BYRNES (627), AMANDA BELANGER (736), MICHELLE BERARDI (679), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 11-15, 18-22, and 25 -26, 2019.

The following intakes submitted to the Director, were inspected during this Resident Quality Inspection:

- One Critical Incident System (CIS) report related to staff to resident neglect and falls prevention;

- Three CIS reports related to resident to resident abuse;

- One CIS report related to the breakdown of the heating system;

- Two CIS reports related to resident's falls which caused a significant change and,

- One CIS report related to the elopement of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MORC), Acting Manager of Resident Care (AMORC), Manager of Therapeutic Services, Manager of Physical Services, Manager of Laundry/Housekeeping, Program Coordinators (PCs), Registered Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RNs), Behavioural Supports Ontario/ Registered Practical Nurses (BSO/RPNs), Registered Practical Nurses (RPNs), Personal Support Workers, (PSWs), Nutritional Aides (NAs), Laundry Aide (LA), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, and 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:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **3 VPC(s)**
- **2 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	Légende 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 there was a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

According to the Long Term Care Homes Act, 2007, neglect is defined 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 Critical Incident System (CIS) report was submitted to the Director for neglect of a resident by a staff member, which resulted in harm or a risk of harm to the resident. The CIS report identified that Personal Support Worker (PSW) #124 informed Registered Nurse (RN) #123 that they had found resident #001, on the floor, and that they had attended to the resident.

Inspector #679 reviewed the "Suspected Resident Abuse/Neglect Report" which had identified that PSW #124 acknowledged that they had not checked on the resident for a specified amount of hours. The "Suspected Resident Abuse/Neglect Report" also identified that PSW #124 notified RN #123, greater than an hour, after they had found the resident on the floor.

Inspector #679 reviewed the typed transcript of an interview between PSW #124 and the management of the home, which identified that PSW #124 had not done a full visual check on resident #001 at the beginning of their shift, that they had not checked that the resident's specific interventions were in place.

Inspector #679 reviewed resident #001's care plan for the focus of "Risk for Falls", which identified that resident #001 was at risk for falls and other specific interventions.

Inspector #679 interviewed PSW #124, who identified that residents were supposed to be checked on every two hours throughout the night, and that staff were to check to ensure that the residents' interventions were implemented at the beginning of their shift. PSW #124 identified that they had not gotten a full visual of resident #001, nor had they identified that the specific interventions were in place.

Inspector #679 interviewed RN #123. They identified that PSW #124 had informed them about the fall of resident #001. RN #123 identified that residents were to be checked on hourly.

A review of the discipline letter addressed to PSW #124 identified that based on their investigation into this concern brought forward, the allegation of resident neglect was substantiated.

Inspector #679 interviewed Program Coordinator (PC) #143, who identified that the allegations of neglect were substantiated.

2. A CIS report was submitted to the Director, in regards to alleged resident to resident abuse. The CIS report indicated that Registered Practical Nurse (RPN) #140 documented that resident #004 had displayed responsive behaviours towards resident #005, for an identified period of time. The CIS report further indicated that RPN #140 failed to report the incident of abuse as per the home's policy.

Inspector #736 interviewed resident #005 regarding the incident. Resident #005 recalled the incident and stated that resident #004 had displayed responsive behaviours towards them and that it had upset them.

Inspector #736 reviewed interview notes between resident #005 and the management from the home, which indicated that the resident had been upset by resident #004's actions.

Inspector #736 reviewed the home's policy, titled "Abuse Resident Abuse/Neglect", last revised September 5, 2018, which indicated that it was the responsibility of all Pioneer Manor employees who have witnessed or suspected that a resident was being abused, the employee was to immediately complete and submit a "Suspected Abuse/Neglect Report" to the Program Coordinator. The policy further indicated that if there was no Program Coordinator on site, the employee was to provide the "Suspected Abuse/Neglect Report" to the RN Supervisor who would then contact the Manager of Resident Care.

Inspector #736 reviewed the investigation package related to the incident. The "Suspected Resident Abuse/Neglect Report" was noted to be in the package and signed by PC #143. In typed interview notes with RPN #140, the RPN indicated that they were to make an incident report and call a PC and RN. The RPN further indicated that they had not known how to move forward with the incident and that they followed up with the resident and thought they had told an RN.

Inspector #736 interviewed RPN #140. The RPN indicated to Inspector #736 that they had not followed the home's policy for prevention of abuse and neglect of a resident in relation to the incident, because they had not notified the RN supervisor at the time of the incident.

Inspector #736 interviewed PC #143. They indicated that the home became aware of the incident between resident #004 and resident #005 one day after the incident. The PC confirmed that RPN #140 had not complied with the home's policy to promote zero tolerance of abuse and neglect of residents in relation to the incident.

3. A CIS report was submitted to the Director regarding allegations of abuse by resident #022 to resident #023, which occurred on two separate occasions.

Inspector #627 reviewed the home's policy, titled "Abuse Resident Abuse/Neglect", last revised September 5, 2018, which indicated that it was the responsibility of all Pioneer Manor employees who have witnessed or suspected that a resident was being abused, the employee was to immediately complete and submit a "Suspected Abuse/Neglect Report" to the Program Coordinator. The policy further indicated that if there was no Program Coordinator on site, the employee was to provide the "Suspected Abuse/Neglect Report" to the RN Supervisor who would then contact the Manager of Resident Care.

Inspector #627 interviewed PSW #153, who stated that resident #022 and #023 had been observed together. PSW #153 stated that they had removed resident #023 at which time resident #023 had voiced complaints of pain. PSW #153 further stated that the resident appeared distressed and upset, which was not their norm. PSW #153 stated that they had then assisted resident #022. PSW #153 stated that resident #022 had demonstrated responsive behaviours at that time. PSW #153 stated that they had reported the incident to the RPN on duty. PSW #153 stated that they could not recall who the RPN was as they had had a lot of different staff on the unit. They further stated that a similar occurrence had occurred two days later and that they had reported the incident to RPN #157.

Inspector #627 interviewed RPN #157, who stated that they had filled an incident report in Point Click Care (PCC), on a specified date, related to the responsive behaviours of resident #022 and #023. They further stated that they had sought out the two PSWs working to make them aware that resident #022 and #023 needed specific interventions. RPN #157 stated that PSW #153 had discussed the incident with them; however, they

had understood this to have occurred in the past, and not on that day. The RPN stated that had they been informed that the incident had occurred earlier that day, they would have notified the RN, assessed both residents immediately, filled a "Resident Abuse/Neglect" report, placed a referral to BSO and contacted the family.

Inspector #627 interviewed RPN #156, who stated that they had worked when resident #022 had additional interventions implemented. At that time, PSW #153 had inquired if resident's #022 was monitored for a specific behaviour and proceeded to inform them of the two alleged incidents. RPN #156 stated that they had reviewed the residents' progress notes and incident reports, and failed to identify any mention of the incidents. They had notified the RN immediately and assessed the residents at this time.

Inspector #627 interviewed PC #148, who stated that the process for reporting suspected abuse was for the PSW to report to the RN when no PCs were in the home. The RN and PSW, together, filled out the report. PC #148 identified that this was not done on both occasions.

Inspector #627 interviewed the Acting Manager of Care (AMORC) who stated that if a PSW suspected or witnessed abuse, they were to contact the RN or PC to report the occurrence and fill out a "Resident Abuse/Neglect" report immediately. The RN would report the occurrence to the PC, who would report to the incidents to the Director. The AMORC further stated that they had only been made aware of the five days after the first incident and that the staff member not reporting to the RN had been "an egregious mistake of our policy".

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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed, corrective action was taken as necessary; and a written record was kept of everything required under clauses (a) and (b).

Inspector #543 reviewed the home's most recent quarterly Medication Incident report. The Incident report identified 107 documented medication related incidents. The Inspector identified that of the 107 medication incidents, two incidents or 1.9 per cent were reviewed, analyzed and corrective action was taken.

The Inspector reviewed the home's policies, "Documentation Incident Report of Unusual Incidents", last revised August 2018, and the "Medication Management Program" , last revised July 2018. Both policies indicated that the PC was responsible for documenting the details of what occurred, indicate any contributing factors and what corrective action was assigned. They were responsible for meeting with the staff member involved in the medication incident, within a two week time frame.

Inspector #679 interviewed PC #146, who verified that no follow up had occurred to identify contributing factors and what corrective actions were to be taken, with regards to a specific medication incident, related to resident #008.

Inspector #543 interviewed the AMORC who indicated that it was a "huge ball drop" in terms of following up on medication incidents. They indicated that they and the pharmacist reviewed the medication incidents on a monthly basis. They identified however, that they had not verified that the review of the medication incidents and follow up with staff had been completed. They indicated that they became aware that PC #118 had not reviewed or analyzed the medication incidents, nor was corrective action taken

as necessary, when the Inspector brought it to their attention.

Inspector #543 interviewed PC #118 regarding the review and corrective actions to be taken for the medication incidents. The PC indicated that they reviewed and followed up on the medication incidents when they had the opportunity to do it. PC #118 indicated that any discussion that had occurred and what corrective actions were initiated would be documented on the spreadsheet, on which all the reported medication incidents were listed. The stated, "the follow up [was] done when [they had] the opportunity to do it". They verified that if there was no review or corrective actions documented on the spreadsheet, the review and corrective actions has not been completed.

Inspector #543 interviewed the MORC, who indicated that PC #118 was responsible for conducting the review and corrective actions related to medication incidents. The MORC verified that no review was conducted, nor were corrective actions taken and documented, related to the last quarterly Medication Incident report. [s. 135. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

A CIS report was submitted to the Director regarding incidents of alleged abuse from resident #022 to resident #023. Please see WN #1, finding #3, for details.

Inspector #627 reviewed the electronic progress notes for resident #022 and #023 and identified a progress note indicating that the resident #022 and #023 were observed with responsive behaviours. The Inspector identified multiple additional progress notes during a specified period of time, indicating that resident #022 and #023 had responsive behaviours towards each other.

Inspector #627 reviewed the home's policy titled, "Responsive Behaviours, Prevention, Assessment and Management of", last revised on November 30, 2018, which indicated that "every effort was made to effectively assess each resident individually and comprehensively through an interdisciplinary team approach. A clearly documented plan of care is in place for the resident that includes information from assessments and consultations with a specialized geriatric mental health outreach team, Physician or Psychiatrist or Nurse Practitioner".

A. Inspector #627 reviewed resident #023's care plan in effect at the time of the incidents, for the focus of responsive behaviours and could not identify a focus for a specific behaviour exhibited by the resident, in the current care plan or prior care plans.

Inspector #627 interviewed PSW #163, who stated that they had observed resident #022 and #023 with responsive behaviours. PSW #163 stated that the residents were separated when they were observed with the responsive behaviours.

Inspector #627 interviewed RPN #156, who stated that resident #022 and #023 were observed frequently with the responsive behaviours; whereby, the staff redirected the two residents. RPN #156 stated that resident #023 was easily redirected; RPN #156 stated that the resident's responsive behaviours had been brought forth to PC #148. RPN #156 further stated that a referral for the responsive behaviours had not been submitted to Behavioral Supports Ontario (BSO), no assessments had been completed to assess resident #022 and #023's specific responsive behaviours and their care plan had not addressed the residents' responsive behaviours, until after the incident of alleged abuse had occurred.

Inspector #627 interviewed BSO RPN #165 who stated that resident #023 had been referred to them after the alleged incidents reported on a specific date. BSO RPN #164 identified that resident #023 had responsive behaviours with a specific number of other

residents. The BSO RPN stated that, as per the home's policy, BSO should have received a referral at any time when two residents demonstrated specific types of behaviours, which had begun when resident #022 was admitted to the home, and that the appropriate assessments and care plan interventions could have been put in place to address resident #023's responsive behaviours.

B. Inspector #627 reviewed resident #022's care plan in effect at the time of the incident, for the focus of responsive behaviours and could not identify a focus for a specific type of responsive behaviour in the current care plan or prior care plans.

Inspector #627 interviewed PSW #153, who stated that resident #022 and #023 displayed specific responsive behaviours. They stated that resident #022 had exhibiting this behaviour since their admission.

Inspector #627 interviewed RN #159 who stated that when two residents displayed responsive behaviours, specific interventions may be implemented. RN #159 stated that none of the identified interventions had been implemented until after they alleged incidents, when a report had been submitted.

Inspector #627 interviewed BSO RPN #165, who stated that they had received a referral for resident #022 after the alleged incident. They stated that they completed a assessment" for resident #022 and initiated specific interventions. They further stated that resident #022's care plan had not been updated until the incident on a specified date, to reflect the resident's responsive behaviours, risk level, triggers and interventions, for the resident's behaviour which had begun at the time of their admission.

Inspector #627 interviewed RPN #158, who stated that when a resident exhibited responsive behaviours, the resident was removed from the situation and brought to their room. The care plan would be updated by the registered staff or BSO, with the triggers, the evidence, the goals and interventions. The RPN stated that when the residents displayed specific responsive behaviours, a type of assessment was to be completed by the RPN or the BSO staff. RPN #158 further stated that this should have been done when resident #022 and #023 displayed specific responsive behaviours, when they were first admitted.

Inspector #627 interviewed RN #166, who stated that when two residents were observed in a specific type of responsive behaviour, specific types of assessments were to be completed, and depending on the findings, the care plan would be updated to reflect a

focus for the responsive behaviours. RN #166 further stated that they had not been made aware of resident #022's responsive behaviours towards resident #023.

Inspector #627 interviewed PC #148, who stated that when residents exhibited a specific type of responsive behaviours, a referral to BSO was sent, and the care plan was updated. PC #148 stated that the assessments determined the level of risk, and this also would be included in the care plan, and that this had not occurred until the incidents were reported on a specified date.

Inspector #627 interviewed the AMORC who stated, "if you are asking if assessments and interventions could have prevented the event, we won't know as they were not done". [s. 26. (3) 5.]

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 the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was secured and locked.

On a specific date, Inspector #736 toured a home area, and noted that the medication cart was in front of the dining room, unlocked, and the RPN responsible for the medication was in the dining room with their back to the medication cart for eight minutes. The Inspector also noted a medication cup with orange liquid on top of the medication cart which was left unattended for four minutes.

Inspector #736 interviewed RPN #112, who indicated that normal process, when completing a medication pass, was to lock the cart while administering the medications to residents. RPN #112 indicated to the Inspector that the orange liquid in the medication cup on top of the medication cart was "Lactulose" and was considered a medication. The RPN indicated that they were aware it was left unattended on the medication cart some time. RPN #112 indicated to Inspector #736 that the medication cart was not kept locked and secured during their medication pass and medications were kept on top of the cart for ease.

On another specified date, Inspector #736 toured a specific home area, and noted the medication cart beside the nursing station, unlocked, with a resident's inhaler on top, as well as a bottle of "Lactulose" for approximately five minutes. There were no staff members in the proximity of the medication cart at the time of the observation.

Inspector #736 interviewed RPN #119, who indicated that the inhaler was a medication and confirmed that the bottle of "Lactulose" still had medication in it and that both had been left out. The RPN indicated that they were not permitted to leave medications on top of the medication cart unattended. The RPN confirmed that during the medication pass, medications had been left on top of the medication cart, unsecured and unattended.

Inspector #736 reviewed the policy titled "Medication Administration", last reviewed April 1, 2018, which indicated that during the administration of medication, the medication cart was to be kept closed and locked while out of sight of the medication nurse and that no medications were to be kept on top of the cart.

Inspector #736 interviewed the AMORC, who confirmed that both "Lactulose" and inhalers were considered medications and were not to be left on top of the medication cart unattended at any time. The AMORC also confirmed that any time the registered staff members were away from the medication cart, the medication cart was to be locked. The AMORC confirmed that in both instances where the Inspector noted medication carts to be unlocked and unattended and medications left on top, the home had not ensured that the medications were kept locked, safe and secured. [s. 129. (1) (a)]

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 drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Inspector #543 reviewed the home's last quarterly "Medication Incident" report, for a specific period of time. The Inspector identified an incident, whereby, resident #008 was administered another resident's medications.

Inspector #543 reviewed the home's "Medication Administration" policy that indicated to administer medications as prescribed by the physician in a safe and effective manner, respecting the ten rights of medication administration. The policy stated that to prevent medication incidents through duplication, omission, incorrect dose, route, and time by using the electronic oneMAR system to guide administration of medications.

Inspector #543 interviewed RPN #158, who indicated that the home's process for medication administration included scanning the medication in the oneMAR system, that all medications for each resident to be administered were indicated in the oneMAR system. They stated they then identified each resident by either their bracelet, the resident seating plan and if still unsure, they verified with full time staff.

Inspector #679 interviewed PC #146, who indicated that they scanned the medications in the oneMAR system and verified that the medications were correct (right medication and right dose). They stated that they had addressed resident #008 by another resident's name and that resident #008 had responded. They indicated that resident #008 had taken the other resident's medications. The PC indicated that when they went to prepare the other resident's medications, they had noticed that this resident's medications had already been signed as administered; which was when they had realized that resident

#008 had received the wrong medications.

Inspector #543 interviewed PC #118, the designate for medication incident follow ups. They indicated that the process for medication administration included following the oneMAR system to ensure that medications were administered based on what was indicated in the medication administration record, and that staff were to sign immediately after the medication administration. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #543 reviewed the home's last quarterly "Medication Incident" report for a specified period of time. The Inspector identified two separate incidents whereby two different residents' medications were signed for in the medication administration record as administered, involving resident #020 and resident #021.

A. Inspector #543 reviewed a medication incident, which identified that resident #020's medications to be administered at a specified time, but were found on the resident's table later during the day.

Inspector #543 reviewed the resident electronic oneMAR, which identified a Physician's order for the medications, to be administered at specified times.

B. Inspector #543 reviewed a medication incident report, which identified that resident #021's medications were found on the medication cart.

Inspector #543 reviewed the resident electronic oneMAR, which identified a Physician's order for the medications to be administered at specified times.

The Inspector reviewed the home's policy titled "Medication Administration", last revised April 2018, which indicated that for oral medication administration, staff were to administer the medication and remain with the resident while medication was swallowed. To prevent medication incidents through duplication, omission, incorrect does, route and time by using the electronic oneMAR system to guide administrations of medications.

Inspector #679 interviewed RN #160, regarding medication administration, who indicated the process included scanning the medication, administering to the resident and then signing for the medication in the medication administration record.

Inspector #679 interviewed PC #146, who indicated that the home's process for medication administration included administering the medication, observe the resident taking the medication and then sign them off as administered in the oneMar medication administration system.

Inspector #543 interviewed the AMORC, who indicated that they administered the medication to resident #020 and had assumed the resident and visitors would ensure the medication was taken. They verified that they had breached the home's Medication policies by not ensuring the resident had taken and swallowed their medications. [s. 131. (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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident, and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A CIS report was submitted to the Director related to resident #002, who fell and sustained a significant change in their health.

Inspector #736 reviewed resident #002's electronic health record, including progress notes, and noted that along with the aforementioned fall, the resident had a previous fall in which the resident had not sustained an injury.

The Inspector reviewed the plan of care in effect at the time of fall and then reviewed the plan of care in effect at the time of the previous fall. The Inspector noted that the resident had utilized a specific mobility aide, along with specific interventions. At this time, RPN #145 had resolved the intervention from the plan of care, and replaced it with an intervention to indicate that resident #002 no longer required the specific mobility aide, along with specific interventions.

Inspector #736 reviewed the resident's progress notes and assessments and was unable

to locate any assessment that indicated the resident no longer required the specific mobility aide, along with specific interventions.

Inspector #736 interviewed RPN #145 regarding the specific mobility aide, along with specific interventions for resident #002. RPN #145 indicated that they had removed the intervention from the plan of care as the resident was displaying responsive behaviours related to the specific mobility aide. The RPN could not recall involving physiotherapy in the decision to remove the intervention.

The Inspector interviewed Registered Physiotherapist (PT) #150 regarding the process of mobility aides for residents. The PT indicated that if staff wished to change the mobility aide of a resident, the registered staff were supposed to send a referral to the Physiotherapy Department to reassess the resident's needs. The PT reviewed the progress notes and assessments for resident #002 and noted that there was no reassessment from physiotherapy in more than one year. PT #150 indicated that they were unaware that a registered staff member had removed the assistive device from resident #002's plan. PT #150 indicated to Inspector #736 that in regards to resident #002 mobility aides, staff had not ensured that the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complimented each other.

In an interview with Inspector #736, PC #147, (Falls Prevention Lead), indicated that when a resident no longer required a mobility aide, the registered staff were to send a referral to the physiotherapy department to have the resident reassessed. Together, Inspector #736 and PC #147 reviewed the plan of care for resident #002 and progress notes and could not locate any indication that the physiotherapy department had been involved in the decision to remove resident #002's mobility aide from their plan of care. PC #147 confirmed that in relation to resident #022's mobility status and interventions, the different care departments had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months, and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

Resident #009 was identified as experiencing altered skin integrity through their prior to most recent Minimum Data Set (MDS) assessment.

Inspector #679 reviewed resident #009's electronic care plan which identified under the focus of "impaired skin integrity" that they were to have a specific intervention.

Inspector #679 completed observations of resident #009 and noted the resident was not receiving the specific intervention.

A review of the progress notes by Inspector #679 identified that the Occupational Therapist had provided resident #009 with another intervention and had removed the specific intervention.

Inspector #679 interviewed PSW #127, who identified that resident #009 experienced altered skin integrity. Together, Inspector#679 and PSW #127 observed resident #009. PSW #127 confirmed that the resident no longer required the specific intervention, and that this should have been changed in the care plan.

Inspector #679 interviewed RPN #128, who identified that resident #009 experienced altered skin integrity and that they had a specific intervention in the past. Together, Inspector #679 and RPN #128 reviewed the current electronic care plan and confirmed that the specific intervention was outlined in the care plan. Inspector #679 and RPN #128 attended resident's #009s room, and RPN #128 confirmed that the resident did not have the specific intervention. RPN #128 indicated they would be updating the care plan.

In an interview with PC #148, they identified that staff would look into a resident's care plan to determine if a resident had altered skin integrity and any interventions that the resident required to manage the altered skin integrity. PC #148 identified that the care plan should be updated whenever there were changes. Inspector #679 reviewed the change in the resident's interventions with PC #148 and they identified that Occupational Therapy would be responsible for updating the care plan if they changed or removed interventions regarding mobility, from the resident's care plan.

Inspector #679 interviewed the Manager of Therapeutic Services who confirmed that the care plan should be updated if there was a change in the resident's care, or equipment was discontinued. [s. 6. (10) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that it was complied with.

In accordance with Ontario Regulation 79/10, r. 89 (1) (iv) the licensee was required to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures were developed to ensure that there was a process to report and locate residents' lost clothing and personal items.

Specifically, staff did not comply with the Memo "New Lost & Found Policy & Labelling Resident Clothing", dated September 13, 2016, which was part of the home's laundry services program.

During an interview with Inspector #679, resident #015 identified that they were missing a personal item, and that they had reported this to staff, but it was not found.

Inspector #679 reviewed the electronic progress notes and observed a progress note, documented by RPN #109, which identified that resident #015 had reported to a PSW that they were missing a personal item.

Inspector #679 interviewed PSW #105, who identified that when a resident reported an item missing, it was to be reported to the RPN, and a "New Lost & Found Policy & Labelling Resident Clothing" form was filled out.

Inspector #679 interviewed RPN #109, who identified that they were not sure of the process for reporting missing items. RPN #109 identified that they called the laundry department, and notified the RN and the PC of the resident's missing item.

Inspector #679 interviewed Laundry Aide (LA) #110, who identified that the "New Lost & Found Policy & Labelling Resident Clothing" was a form that staff filled out for the missing item and that the forms went to their supervisor.

Inspector #679 interviewed the MORC, who identified that the home did not have a policy for missing clothing and items, but that a memo, "New Lost & Found Policy & Labelling Resident Clothing", was posted for staff.

Inspector #679 reviewed the memo titled, "New Lost & Found Policy & Labelling Resident Clothing", which identified that "Residents and their families [were] asked to immediately report any lost personal item(s) by completing the new Lost and Found Items Report. The memo then identified that completed copies were to be submitted electronically or left in the lock box attached to the clothing depot.

Inspector #679 interviewed the Laundry and Housekeeping Supervisor #116 who identified that families or staff filled out a "New Lost & Found Policy & Labelling Resident Clothing" form when it was identified that residents were missing clothing or personal items. The Laundry and Housekeeping Supervisor identified that these forms were collected and placed in a bin in their office. The Inspector asked if they had a missing item report form for resident #015's personal item. The Laundry and Housekeeping Supervisor reviewed the documents and identified they had not received a form for resident #015's missing personal item. [s. 8. (1) (b)]

2. In accordance with Ontario Regulation 79/10, r. 49, the licensee must ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's policy regarding "Falls and Fall Related Injuries: Assessment, Reduction and Management", last revised March 2, 2018, which was part of the home's fall management program.

A CIS report was submitted to the Director which identified that PSW #124 informed RN #123 they had found resident #001 after they had fallen, and that they had provided the resident with a specific intervention. Please see WN #1, finding #1 for details.

Inspector #679 reviewed the typed transcript of an interview with PSW #124, which identified that they had assisted resident #001. The interview further identified that PSW #124 had not assisted the resident as specified in the home's policy.

Inspector #679 reviewed the home's policy titled, "Falls and Fall Related Injuries: Assessment, Reduction and Management", last revised March 2, 2018, which identified how a resident was to be assisted, including assessment by a registered nursing staff or the nursing supervisor.

Inspector #679 interviewed PSW #124, who identified that resident #001 had fallen and that they had provided the resident with a specific interventions. PSW #124 identified that they later reported what had happened to the RN. PSW #124 identified that the home's process for when a resident fell was to notify the registered staff before providing a resident with a specific intervention.

Inspector #679 interviewed RN #123, who identified that the PSW told them that the resident had fallen, and that they had provided them with a specific intervention, as the resident had not been provided with another specific intervention prior to their fall. RN #123 identified that staff were to provide the specific intervention as indicated in the home's policy.

Inspector #679 interviewed PC #143, who identified that PSW #124 had not followed the home's policy as they had not notified the RN to complete their assessment after the residents fall, and they had not provided the resident with interventions as indicated in the home's policy.

WN #8: 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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

During an interview with Inspector #679 resident #016 stated that a staff member had used vulgar language towards them, and that they had reported this allegation to a PSW.

Inspector #679 brought forth the allegation of abuse to the MORC, on a specified date.

Inspector #679 reviewed the Ministry of Health and Long Term Care (MOHLTC)'s online reporting portal, and failed to identify that a CIS report was submitted in relation to this allegation of abuse.

Inspector #679 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect" last revised September 5, 2018, which identified that any person who had the reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by employees that resulted in harm or a risk of harm to the resident.

Inspector #679 interviewed the MORC who identified that PC #118 had completed an investigation into the incident immediately upon becoming aware of the allegation. The MORC identified that the home spoke with the PSW who the resident identified they reported it to, and they searched the schedule for the staff members name and could not identify a staff member who was employed in the home with the name that matched the description provided by resident #016. The MORC identified that they had not reported the allegation of abuse to the MOHLTC based on the decision tree, and that they felt there was no reasonable grounds to suspect that this event had occurred and that there was no staff member working in the home by the identified name. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

Inspector #543 reviewed the home's last quarterly Medication Incident report. Upon reviewing the report, the Inspector identified that on three separate occasions controlled substances were missing.

Inspector #543 reviewed the home's policy titled, "Medication Administration: Controlled Substances", last revised November 2018. The policy identified that when a discrepancy in a controlled substance record was identified; the Program Coordinator initiated and submited the on-line critical incident system form within one business day of the incident and completed a full report with ten days of becoming aware of the incident. The policy described that the MORC or designate would notify the Sudbury Regional Policy department and completed the "Loss of Theft Form for Controlled Substance and Precursors" and fax to Health Canada.

Inspector #543 reviewed the Ministry of Health and Long Term Care (MOHLTC) reporting system and failed to identify any reports related to the aforementioned missing controlled substances that were identified by the licensee, for the specified time frame.

Inspector #543 interviewed the MORC who indicated that they were responsible for reporting any medication incidents, including missing controlled substances to the Director. They verified that they had not reported the missing controlled substances to the Director, that the Inspector brought forward related to the last quarterly review. [s. 107. (3) 3.]

Issued on this 23rd day of April, 2019

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

Ministère 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) :	SYLVIE BYRNES (627), AMANDA BELANGER (736), MICHELLE BERARDI (679), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2019_752627_0005
Log No. / No de registre :	003979-19
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 5, 2019
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

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

Ministère 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

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

Ministère 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. 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 be compliant with s. 20 (1) of the Long term Care Homes Act (LTCHA).

Specifically, the licensee must;

Ensure that all staff of the home comply with the home's written policy to promote zero tolerance of abuse and neglect of residents specifically but not limited to,

a) Ensure that all employees who have witnessed or suspect that a resident is being abused or neglected immediately report the allegations as per the home's policy; and,
b) Develop and implement a process to ensure that staff are aware and understand what constitutes a suspicion of abuse and that they must report it immediately; and,
c) Develop and implement a process to ensure that staff are aware and understand what constitutes abuse and neglect of a resident and that they must report it immediately.

Grounds / Motifs :

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

According to the Long Term Care Homes Act, 2007, neglect is defined 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 Critical Incident System (CIS) report was submitted to the Director for neglect of a resident by a staff member, which resulted in harm or a risk of harm to the resident. The CIS report identified that Personal Support Worker (PSW) #124 informed Registered Nurse (RN) #123 that they had found resident #001, on the floor, and that they had attended to the resident.

Inspector #679 reviewed the "Suspected Resident Abuse/Neglect Report" which had identified that PSW #124 acknowledged that they had not checked on the resident for a specified amount of hours. The "Suspected Resident Abuse/Neglect Report" also identified that PSW #124 notified RN #123, greater than an hour, after they had found the resident on the floor.

Inspector #679 reviewed the typed transcript of an interview between PSW #124 and the management of the home, which identified that PSW #124 had not done a full visual check on resident #001 at the beginning of their shift, that they had not checked that the resident's specific interventions were in place.

Inspector #679 reviewed resident #001's care plan for the focus of "Risk for Falls", which identified that resident #001 was at risk for falls and other specific interventions.

Inspector #679 interviewed PSW #124, who identified that residents were supposed to be checked on every two hours throughout the night, and that staff were to check to ensure that the residents' interventions were implemented at the beginning of their shift. PSW #124 identified that they had not gotten a full visual of resident #001, nor had they identified that the specific interventions were in place.

Inspector #679 interviewed RN #123. They identified that PSW #124 had informed them about the fall of resident #001. RN #123 identified that residents were to be checked on hourly.

A review of the discipline letter addressed to PSW #124 identified that based on their investigation into this concern brought forward, the allegation of resident neglect was substantiated.

Inspector #679 interviewed Program Coordinator (PC) #143, who identified that the allegations of neglect were substantiated.
(679)

2. A CIS report was submitted to the Director, in regards to alleged resident to resident abuse. The CIS report indicated that Registered Practical Nurse (RPN) #140 documented that resident #004 had displayed responsive behaviours towards resident #005, for an identified period of time. The CIS report further indicated that RPN #140 failed to report the incident of abuse as per the home's policy.

Inspector #736 interviewed resident #005 regarding the incident. Resident #005 recalled the incident and stated that resident #004 had displayed responsive behaviours towards them and that it had upset them.

Inspector #736 reviewed interview notes between resident #005 and the management from the home, which indicated that the resident had been upset by resident #004's actions.

Inspector #736 reviewed the home's policy, titled "Abuse Resident Abuse/Neglect", last revised September 5, 2018, which indicated that it was the responsibility of all Pioneer Manor employees who have witnessed or suspected that a resident was being abused, the employee was to immediately complete and submit a "Suspected Abuse/Neglect Report" to the Program Coordinator. The policy further indicated that if there was no Program Coordinator on site, the employee was to provide the "Suspected Abuse/Neglect Report" to the RN Supervisor who would then contact the Manager of Resident Care.

Inspector #736 reviewed the investigation package related to the incident. The "Suspected Resident Abuse/Neglect Report" was noted to be in the package and signed by PC #143. In typed interview notes with RPN #140, the RPN indicated that they were to make an incident report and call a PC and RN. The RPN further indicated that they had not known how to move forward with the

incident and that they followed up with the resident and thought they had told an RN.

Inspector #736 interviewed RPN #140. The RPN indicated to Inspector #736 that they had not followed the home's policy for prevention of abuse and neglect of a resident in relation to the incident, because they had not notified the RN supervisor at the time of the incident.

Inspector #736 interviewed PC #143. They indicated that the home became aware of the incident between resident #004 and resident #005 one day after the incident. The PC confirmed that RPN #140 had not complied with the home's policy to promote zero tolerance of abuse and neglect of residents in relation to the incident.
(736)

3. A CIS report was submitted to the Director regarding allegations of abuse by resident #022 to resident #023, which occurred on two separate occasions.

Inspector #627 reviewed the home's policy, titled "Abuse Resident Abuse/Neglect", last revised September 5, 2018, which indicated that it was the responsibility of all Pioneer Manor employees who have witnessed or suspected that a resident was being abused, the employee was to immediately complete and submit a "Suspected Abuse/Neglect Report" to the Program Coordinator. The policy further indicated that if there was no Program Coordinator on site, the employee was to provide the "Suspected Abuse/Neglect Report" to the RN Supervisor who would then contact the Manager of Resident Care.

Inspector #627 interviewed PSW #153, who stated that resident #022 and #023 had been observed together. PSW #153 stated that they had removed resident #023 at which time resident #023 had voiced complaints of pain. PSW #153 further stated that the resident appeared distressed and upset, which was not their norm. PSW #153 stated that they had then assisted resident #022. PSW #153 stated that resident #022 had demonstrated responsive behaviours at that time. PSW #153 stated that they had reported the incident to the RPN on duty. PSW #153 stated that they could not recall who the RPN was as they had had a lot of different staff on the unit. They further stated that a similar occurrence had occurred two days later and that they had reported the incident to RPN #157.

Inspector #627 interviewed RPN #157, who stated that they had filled an incident report in Point Click Care (PCC), on a specified date, related to the responsive behaviours of resident #022 and #023. They further stated that they had sought out the two PSWs working to make them aware that resident #022 and #023 needed specific interventions. RPN #157 stated that PSW #153 had discussed the incident with them; however, they had understood this to have occurred in the past, and not on that day. The RPN stated that had they been informed that the incident had occurred earlier that day, they would have notified the RN, assessed both residents immediately, filled a "Resident Abuse/Neglect" report, placed a referral to BSO and contacted the family.

Inspector #627 interviewed RPN #156, who stated that they had worked when resident #022 had additional interventions implemented. At that time, PSW #153 had inquired if resident's #022 was monitored for a specific behaviour and proceeded to inform them of the two alleged incidents. RPN #156 stated that they had reviewed the residents' progress notes and incident reports, and failed to identify any mention of the incidents. They had notified the RN immediately and assessed the residents at this time.

Inspector #627 interviewed PC #148, who stated that the process for reporting suspected abuse was for the PSW to report to the RN when no PCs were in the home. The RN and PSW, together, filled out the report. PC #148 identified that this was not done on both occasions.

Inspector #627 interviewed the Acting Manager of Care (AMORC) who stated that if a PSW suspected or witnessed abuse, they were to contact the RN or PC to report the occurrence and fill out a "Resident Abuse/Neglect" report immediately. The RN would report the occurrence to the PC, who would report to the incidents to the Director. The AMORC further stated that they had only been made aware of the five days after the first incident and that the staff member not reporting to the RN had been "an egregious mistake of our policy".

The severity of this issue was determined to be a level two, as there was potential for harm. The scope of the issue was a level two, as it was identified that multiple residents were affected. The home had a level three compliance history, as they had one or more related non compliance in the last three years

within this section of the LTCHA that included:

- one Voluntary Plan of Correction (VPC) issued December 13, 2018, during inspection 2018_669642_0030; and,
- one Written Notification (WN) issued March 13, 2018, during inspection 2018_435621_0007;
- one WN issued on February 14, 2018, during inspection 2018_669642_0002;
- one Compliance Order (CO) issued on December 28, 2017, during inspection 2017_657681_0015;
- one Director Referral (DR) issued on August 21, 2017, during inspection 2017_657681_0004; and,
- one DR issued on July 31, 2017, during inspection 2017_616542_0010.

(627)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 03, 2019

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

Ministère 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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall be compliant with s. 135 (2) of Ontario Regulation (O.Reg.) 79/10 of the Long term Care Homes Act (LTCHA).

Specifically, the licensee shall:

a) Complete a review to determine the "Medication Incident" reports that were not reviewed and analyzed;
b) Ensure that all "Medication Incident" reports which occurred in the last quarter, and any other that may not have been completed, are reviewed and analyzed, including taking corrective action where necessary and documented; and,
c) Develop and implement a process to ensure that the designated staff member completes employee follow up with staff, within the home's allotted time frame.

Grounds / Motifs :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed, corrective action was taken as necessary; and a written record was kept of everything required under clauses (a) and (b).

Inspector #543 reviewed the home's most recent quarterly Medication Incident report, from October, 2018 to December, 2018. The Incident report identified

107 documented medication related incidents. The Inspector identified that of the 107 medication incidents, two incidents or 1.9 per cent were reviewed, analyzed and corrective action was taken.

The Inspector reviewed the home's policies, "Documentation Incident Report of Unusual Incidents", last revised August 2018, and the "Medication Management Program" , last revised July 2018. Both policies indicated that the PC was responsible for documenting the details of what occurred, indicate any contributing factors and what corrective action was assigned. They were responsible for meeting with the staff member involved in the medication incident, within a two week time frame.

Inspector #679 interviewed PC #146, who verified that no follow up had occurred to identify contributing factors and what corrective actions were to be taken, with regards to the medication incident that occurred on December 30, 2018, related to resident #008.

Inspector #543 interviewed the AMORC who indicated that it was a "huge ball drop" in terms of following up on medication incidents. They indicated that they and the pharmacist reviewed the medication incidents on a monthly basis. They identified however, that they had not verified that the review of the medication incidents and follow up with staff had been completed. They indicated that they became aware that PC #118 had not reviewed or analyzed the medication incidents, nor was corrective action taken as necessary, when the Inspector brought it to their attention.

Inspector #543 interviewed PC #118 regarding the review and corrective actions to be taken for the medication incidents. The PC indicated that they reviewed and followed up on the medication incidents when they had the opportunity to do it. PC #118 indicated that any discussion that had occurred and what corrective actions were initiated would be documented on the spreadsheet, on which all the reported medication incidents were listed. The stated, "the follow up [was] done when [they had] the opportunity to do it". They verified that if there was no review or corrective actions documented on the spreadsheet, the review and corrective actions has not been completed.

Inspector #543 interviewed the MORC, who indicated that PC #118 was

responsible for conducting the review and corrective actions related to medication incidents. The MORC verified that no review was conducted, nor were corrective actions taken and documented, related to the last quarterly Medication Incident report.

The severity of this issue was determined to be a level two, as there was potential for harm. The scope of the issue was a level three, as it was widespread to many residents. The home had a level two compliance history of one or more unrelated non-compliance in the last three years. (543)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 5th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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