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
Jul 8, 2019	2019_786744_0018	005894-19, 006635-19, 007160-19, 008013-19, 008898-19, 009145-19, 010328-19	Critical Incident System

Licensee/Titulaire de permis

City of Greater Sudbury
200 Brady Street 4th Floor SUDBURY ON P3E 3L9

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

STEVEN NACCARATO (744), LOVIRIZA CALUZA (687), SHELLEY MURPHY (684)

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): June 10-14, 2019

The following intakes were inspected during the Critical Incident System (CIS) inspection:
-Four intakes related to falls that resulted in injury;
-Two intakes related to alleged staff to resident abuse;
-One intake related to resident to resident abuse.

Follow-up inspection #2019_786744_0019 and Complaint inspection #2019_786744_0020 were conducted concurrently with this inspection.

PLEASE NOTE: A Voluntary Plan of Correction (VPC) related to section (s.) 20. (1) of the Long Term Care Homes Act (LTCHA), 2007, was identified in this inspection and has been issued in the Follow-up inspection report #2019_786744_0019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director, Acting Manager of Resident Care (AMORC), Manager of Resident Care (MORC), Manager of Administration (MOA), Nutritional aide, Program Coordinators (PCs), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietitian (RD), Physician, Manager of Therapeutic Services (MOTS), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), family members and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed residents’ health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personnel records, observed resident rooms, observed resident common areas, 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.

1 WN(s)
0 VPC(s)
0 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 O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to enure that in making a report to the Director under subsection 23 (2) of the Act, the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report incident, was included: (2) A description of the individuals involved in the incident, including, (ii) names of any staff members or other persons who were present at or discovered the incident.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001 was alleged to have been abused by a staff member. It was reported by resident #010 that PSW #125 stated inappropriate comments and displayed a rough gesture towards resident #001.

Inspector #687 reviewed the home's policy titled "Documentation: Report of Critical Incidents", which indicated that within 10 days of becoming aware of the incident or sooner if required by the Director [under the Act], the Program Coordinator will make a report in writing to the Director [under the Act], indicating the following:

- A description of the individuals involved in the incident including the names of any staff members or other persons who were present at or discovered the incident.

In a review of the CI report submitted by the home, Inspector #687 did not identify the staff who was involved in the alleged abuse of resident #001.

In an interview conducted by Inspector #687 with PSW #126, they indicated that they received a verbal report of the alleged abuse incident from resident #010 regarding PSW #125's comments and action towards resident #001.

During an interview with PSW #125, they acknowledged that they were involved in the alleged abuse of resident #001.

In an interview with Program Coordinator #3, they verified that PSW #125 was the staff member who was identified in the alleged abuse of resident #001 in the CI report that was submitted to the Director. They further stated that they were supposed to include the names of all the individuals including the staff that was involved in the alleged abuse incident. The Program Coordinator stated that they had amended the CI report, and acknowledged that they missed to include the name of the alleged staff member in the CI report. [s. 104. (1) 2. ii.]

Issued on this 10th day of July, 2019

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

Original report signed by the inspector.