Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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_0019	008418-19, 008419-19	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): June 10-14, 2019

The following intakes were inspected on during this Follow-up inspection:
-One intake related to Compliance Order (CO) #001 issued during inspection #2019_752627_0005, pursuant to the Long-Term Care Homes Act (LTCHA),2007, s. 20. (1) regarding the home's zero tolerance of abuse policy.
-One intake related to Compliance Order (CO) #002 issued during inspection #2019_752627_0005, pursuant to the Long-Tern Care Homes Act (LTCHA),2007, r. 135. (2) regarding medication incidents.

Complaint inspection #2019_786744_0020 and Critical Incident System inspection #2019_786744_0018 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, identified in a concurrent inspection #2019_786744_0018 was issued in this report.

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:
Medication
Prevention of Abuse, Neglect and Retaliation

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 135. (2)	CO #002	2019_752627_0005	684
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2019_752627_0005	687

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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

During Inspection #2019_752627_0005, CO #001 was issued to the home, which ordered the licensee to be compliant with s.20 (1) of the Long term Care Homes Act (LTCH).

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.

The compliance due date of this order was May 03, 2019. While the licensee complied with the sections of CO #001, additional non-compliance was identified during the course of the inspection.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #002 was alleged to have been abused by PSW #123.

A) Inspector #687 reviewed the home's policy titled "Abuse: Resident Abuse & Neglect", which indicated that "The Licensee has a policy of not tolerating resident abuse/neglect by ensuring that swift and certain action is taken in response to incidents of abuse/neglect or reports of abuse/neglect. A zero tolerance policy removes discretionary power from decision makers by making consequences mandatory. Resident abuse/neglect is a serious matter and any incidents of substantiated abuse/neglect will lead to disciplinary action up to and including termination with cause".

Inspector #687 reviewed the home's internal investigation which identified that RPN #128's statement described the interaction between PSW #125 and resident #002.

In a subsequent record review of the home's internal investigation, it was documented that PSW #123 was providing care to resident #002. PSW #123's statement indicated

that they were in a room with resident #002 when the resident demonstrated specific responsive behaviors and injured the PSW.

In an interview conducted by Inspector #687, PSW #123 stated that they were assisting resident #002 with their personal care when the resident demonstrated specific responsive behaviors and injured them. The PSW described how they responded towards the resident, until the resident's specific responsive behavior towards the PSW ended.

During an interview with RPN #128, they described to the Inspector the interaction between PSW #123 and resident #002.

In an interview conducted by Inspector #687 with Program Coordinator (PC) #3, they stated that they were taking notes when PC #4 interviewed PSW #123. PC #3 stated that PSW #123 verified that their actions towards resident #002 and acknowledged that it was inappropriate. PC #3 stated that PSW #123's abuse was substantiated towards resident #002. The PC stated that PSW #123 received disciplinary action.

B) Inspector #687 reviewed the home's policy titled "Abuse: Resident Abuse & Neglect' last revised March 2 5, 2019, which indicated that, "All Pioneer Manor employees, volunteers, students or service providers who interact with that resident, who have witnessed or suspect that a resident is being abused/neglected, must report the allegation immediately to the Home Area Resident Care Coordinator or Manager of Resident Care if after hours, as well as to the Director of Long-Term Care Homes. Communication with the Manager of Resident Care is facilitated by the Registered Nurse".

During an interview with RPN #128, they stated they reported the abuse of resident #002 to the RN hours after the incident occurred. The RN advised the RPN to report the alleged abuse incident to the Program Coordinator.

In an interview with Program Coordinator #3, they stated that the alleged abuse incident regarding resident #002 occurred hours before RPN #128 reported it to them. They further stated that their expectation from their staff members regarding reporting of any alleged, witnessed or reported abuse was to report it immediately to the Program Coordinator and the Manager of Resident Care. And if it was after business hours or night shift, the staff were expected to report to the RN Supervisor who would then call the Resident Care Manager for further directions. The Program Coordinator acknowledged

that the alleged abuse of resident #002 was reported late by RPN #128.

2. The home submitted a CI report to the Director, which indicated that resident #001 was alleged to have been abused by PSW #125.

Inspector #687 reviewed the home's internal investigation which identified that RPN #130 described an interaction between PSW #125 and resident #001 while the resident was completing a task.

In an interview conducted by Inspector #687 with resident #010, they stated what they observed between PSW #125 and resident #001. Resident #010 stated that PSW #125's actions were not fair and respectful to resident #001.

During an interview with PSW #126, they described what resident #010 reported to them between PSW #125 and resident #001.

In an interview conducted by Inspector #687, PSW #125 denied the allegation of abuse towards resident #001. The PSW stated that resident #001 required assistance with a specific task, they asked to help the resident with that task and denied the allegations.

In an interview conducted by Inspector #687 with Program Coordinator #3, they stated that based on their internal investigation, PSW #125's interaction with resident #001 was inappropriate and that it was substantiated as abuse.

This finding of non-compliance is further evidence to support the compliance order that was issued to the licensee on April 5, 2019, during the Resident Quality Inspection #2019_752627_0005, which had a compliance due date of May 3, 2019. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, to be implemented voluntarily.

WN #2: 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.

During the review of the "Medication Incident" reports; Inspector #684 identified three reports for missing controlled substances.

Inspector #684 reviewed the home's policy titled, "Medication Administration: Controlled Substances", which was in place at the time of the incidents, with a revision date of November 23, 2018, which stated the following under the title of "Discrepancy in Controlled Substance Report -To ensure compliance with the LTCH Act2007; s. 24 (1), the Program Coordinator will initiate and submit the on-line Critical Incident System (CIS) form within one (1) business day of the incident and complete a full report within ten (10) days of becoming aware of the incident".

Inspector #684 reviewed the Ministry of Health and Long Term Care (MOHLTC) reporting system used for reporting Critical Incidents (CIs) and was unable to locate any reports for the above noted missing controlled substances that were identified on the Medication Incident reports.

During an interview with PC #121, Inspector #684 reviewed two of the missing controlled substance Medication Incident reports that they were involved with and asked if the missing controlled substances were reported to the MOHLTC. They responded "No they were not". Inspector #684 asked why the missing controlled substances were not reported to the MOHLTC, PC #121 stated "Unsure why not reported, but according to the policy they should have been".

Inspector #684 interviewed the MORC who indicated that they are to report missing controlled substances to the MOHLTC within 24 hours and complete the CI. [s. 107. (3) 3.]

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.