Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 5, 2021	2020_853692_0012	013034-20, 015841-20, 017337-20, 017429-20, 017944-20, 018151-20, 018648-20, 018665-20, 019059-20, 019385-20, 019401-20, 019790-20, 021865-20, 022416-20	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

SHANNON RUSSELL (692), JENNIFER BROWN (647), LOVIRIZA CALUZA (687), MICHELLE BERARDI (679), SYLVIE BYRNES (627)

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): December 14-18, 2020.

The following intake(s) were inspected upon during this Critical Incident System Inspection:
-Two logs, which were related to critical incidents that the home submitted to the Director related to incidents of missing/unaccounted for controlled substances;

-Four logs, which were related to critical incidents that the home submitted to the Director related to incidents that caused an injury to a resident for which the resident was transferred to the hospital; and,

-Eight logs, which were related to critical incidents that the home submitted to the Director related to abuse of a resident that caused harm or the risk of harm.

A Complaint Inspection #2020_853692_0011 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Long Term Care Services for Pioneer Manor, Manager of Resident Care (MORC), Resident Care Coordinators (RCC), Behavioural Supports Ontario (BSO) staff, Scheduling Coordinator, RAI-Coordinator (RAI-C), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

7 WN(s)
4 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 a Personal Support Worker (PSW) complied with the home's written policy to promote zero tolerance of resident abuse/neglect, when providing care to a resident.

The home's policy "Abuse: Resident Abuse/Neglect", defined neglect as failing to provide a resident with the services required for health, safety or well-being, and deliberately failing to meet a dependent resident's needs as identified in [their] plan of care.

Review of a Critical Incident System (CIS) report and interview with a Resident Care Coordinator (RCC) described that a PSW had performed care on a resident that was not consistent with their transfer needs; the resident sustained a fall due to the PSW's inaction.

The resident had been identified as a moderate fall risk with specific transfer intervention that they required to ensure the residents safety.

The home's internal investigation notes identified substantiated neglect by not following the home's policies, placing a resident at risk.

Sources: CIS report; resident progress notes and care plan, internal investigation notes, home's policy "Abuse: Resident Abuse/Neglect, interviews with a RCC and other staff. [s. 20. (1)]

2. The licensee has failed to ensure that a PSW complied with the home's written policy to promote zero tolerance of resident abuse/neglect, when providing care to a resident.

Emotional abuse is defined within the O. Reg. 79/10 of the LTCHA, 2007, as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident”. Verbal abuse is defined as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident”.

A resident had requested a PSW to provide them assistance, when the PSW refused, they spoke to them in an inappropriate manner. Another PSW identified that they had observed this and indicated that the resident had become very upset saying the way the PSW talked to them was “disrespectful and not dignified”.

A RCC indicated that an allegation of neglect towards a resident had been founded for not complying with the home’s abuse policy, as they were verbally abusive causing the resident to suffer emotional distress and a lack of dignity.

Sources: CIS report; resident progress notes and care plan; review of the internal investigation notes; home’s policy “Abuse: Resident Abuse/Neglect; and interviews with a PSW, a RCC and other staff. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 a resident had the interventions in place to manage their responsive behaviours, as specified in their care plan.

A resident was determined to be high risk for responsive behaviours towards others. The care plan for the resident indicated that staff were to ensure a barrier was in place to mitigate the resident's responsive behaviours. There were multiple observations by the Inspector where the barrier was not in place. A Behavioural Supports Ontario (BSO) PSW indicated that staff were to ensure the barrier was to be in place at all times.

Sources: CIS report; a residents care plan; Inspector's observations; and interviews with a RCC and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that a resident had a fall prevention item in place as specified in the plan.

Resident #007 had an unwitnessed fall, which resulted in a significant injury. A review of the CIS report indicated that the resident did not have their fall prevention item in place at the time of the fall incident.

During separate interviews with a PSW and a Registered Nurse (RN), they indicated that they had responded to the resident when they had fallen and identified that the resident did not have their fall prevention item in place, as specified in the resident's care plan.

Sources: CIS report; review of the home's "Documentation Resident Care Plan" policy;

review of a resident's electronic progress notes; care plan and Fall Risk Assessment; and interviews with a PSW, a RN and other staff. [s. 6. (7)]

3. The licensee has failed to ensure that a resident had a fall prevention item in place as specified in the plan.

Resident #009 had an unwitnessed fall, which resulted in an injury. A review of the resident's progress notes, indicated that the resident did not have their fall prevention item in place at the time of the fall incident.

During an interview with a RN, they verified that the resident was a high risk for falls and that when the resident fell they did not have their fall prevention item in place as stated in their care plan. A RCC stated that the staff members were to ensure that their fall prevention item was in place at all times and that the staff did not follow the residents care plan.

Sources: CIS report; review of the home's "Documentation Resident Care Plan" policy; review of resident electronic progress notes; care plan and Fall Risk Assessment; and interviews with a RN and a RCC. [s. 6. (7)]

4. The licensee has failed to ensure that the care plan for a resident was reviewed and revised with respect to a barrier.

A resident's care plan indicated a barrier was to be implemented in order to mitigate the risk of harm from other residents exhibiting responsive behaviours. The Inspector observed on multiple occasions that the barrier was not in place. In separate interviews with a PSW and a RCC, they both indicated that the barrier may be outdated, as there had been no further concerns and it was no longer required.

Sources: CIS report; a residents care plan; Inspector’s observation; "Documentation Resident Care Plan" policy; interviews with a RCC and other staff. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when, a goal in the plan is met, the resident's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 a RPN complied with the policy and procedure when administering a controlled substance to a resident.

O. Reg. 79/10, s. 114 (2) requires that the home have written policies and procedures for the medication management system.

Specifically, a RPN did not comply with the protocols in the home's policy titled, "Medication Administration: Controlled substances". The registered staff member was to document on a separate line of the record each time a narcotic or controlled drug was administered, which indicated the date, time, registered staff member's signature, and amount given. As well, the home's policy titled "Medication Administration", included the following direction for staff, "post administration [of the medication], document administration in oneMAR".

Two CIS reports were submitted to the Director regarding missing controlled substances. The CIS reports indicated that on two occasions, controlled substances were unaccounted for when the controlled substance count was completed at the end of shift.

A review of a resident's medication administration record (oneMAR) and controlled substance count sheet revealed that on six separate dates the controlled substance count sheet indicated that the medications were removed ranging from 45 minutes to three and a half hours after the oneMAR indicated that the resident had received the controlled substance. The residents controlled substance count sheet also indicated that a medication had been removed at three different times; however, oneMAR only indicated two administrations recorded.

During an interview with a RPN, they acknowledged that they had not signed the "record" and the oneMar when they had administered the medications, and they should have.

Sources: physician's order form; home's policies titled "Medication Administration: Controlled substances" and "Medication Administration"; oneMAR and medication count sheet for the period reviewed; and interviews with the MORC and other staff. [s. 8. (1) (b)]

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 home's medication administration policies are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the assessments taken in response to residents exhibiting responsive behaviours were documented.

There were three separate incidents of resident to resident abuse that had occurred. As a result of these incidents, a monitoring process was to be implemented for all three residents who had exhibited the responsive behaviours towards the other residents. A review of the documentation for the three residents identified that the documentation was incomplete.

During separate interviews with the direct care nursing staff, they all indicated that they had not completed the documentation of the monitoring process, and they should have.

Sources: CIS reports; Responsive Behaviour policy; three resident's health care records; interviews with the MORC and other staff. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, 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. (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 a RPN administered a medication to a resident in accordance with the directions for use specified by the prescriber.

Two CIS reports regarding missing medications were submitted to the director.

A review of a resident's oneMAR and the resident's controlled substance count sheet revealed that on four separate dates the resident had received a medication ranging from one hour to one hour and 34 minutes apart. A physician's order, for the resident indicated that the resident was to receive the prescribed medication, as required every two hours.

The home's policy titled "Medication Administration", directed staff to administer a medication as prescribed by the Physician in a safe and effective manner, respecting the ten rights of medication administration, including the following: Right time and frequency.

During an interview with the RPN, they acknowledged that they had provided the medication earlier than every two hours, to a resident, and they should not have.

Sources: CIS reports; the home's investigation notes; home's policy titled "Medication Administration"; oneMar and controlled substance count sheet for the month reviewed; and interviews with the MORC and other staff. [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 drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an incident of alleged abuse by a resident towards another resident.

The home's prevention of abuse and neglect policy indicated that the RCC was to notify the police immediately of any alleged, suspected or witnessed incident of abuse or neglect that may constitute a criminal offence.

A review of an email addressed to a RCC, indicated that the police report of an incident of resident to resident abuse was not submitted until eight days after the incident had occurred.

Sources: CIS report; Abuse: Resident Abuse/Neglect policy; interview with staff; and Email, subject: Your Online Police Report. [s. 98.]

WN #7: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director within 10 days of becoming aware of an incident, the names of any staff member who were present or discovered the incident.

A review of two CIS reports for residents that had sustained falls resulting in injuries, identified that both CIS reports included details of the fall incidents, the actions taken in response to the residents falls; however both reports had not included the names of the staff that had responded to the incidents.

Sources: CIS reports; review of the home’s "Report of Critical Incident" policy; review of residents' progress notes; and interviews with staff. [s. 107. (4) 2. ii.]

Issued on this 7th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SHANNON RUSSELL (692), JENNIFER BROWN (647), LOVIRIZA CALUZA (687), MICHELLE BERARDI (679), SYLVIE BYRNES (627)
Inspection No. / No de l’inspection :	2020_853692_0012
Log No. / No de registre :	013034-20, 015841-20, 017337-20, 017429-20, 017944-20, 018151-20, 018648-20, 018665-20, 019059-20, 019385-20, 019401-20, 019790-20, 021865-20, 022416-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 5, 2021
Licensee / Titulaire de permis :	City of Greater Sudbury 200 Brady Street, 4th Floor, Sudbury, ON, P3E-3L9
LTC Home / Foyer de SLD :	Pioneer Manor 960 Notre Dame Avenue, Sudbury, ON, P3A-2T4
	Aaron Archibald

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

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 Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 001

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

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 must be compliant with s. 20 (1) of the Long Term Care Home's Act (LTCHA), 2007.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

The plan must include, but is not limited to, the following:
a) how the licensee will ensure that the policy promoting zero tolerance of abuse and neglect is complied with;

b) implement a monitoring system to ensure that all staff comply with the home's policy regarding zero tolerance of abuse and neglect, and maintain a written record of the monitoring system.

Please submit the written plan, quoting inspection #2020_853692_0012 and Inspector Shannon Russell, by email to SudburySAO.moh@ontario.ca by January 19, 2021.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

Grounds / Motifs :

1. The licensee has failed to ensure that a Personal Support Worker (PSW) complied with the home's written policy to promote zero tolerance of resident

abuse/neglect, when providing care to a resident.

The home's policy "Abuse: Resident Abuse/Neglect", defined neglect as failing to provide a resident with the services required for health, safety or well-being, and deliberately failing to meet a dependent resident's needs as identified in [their] plan of care.

Review of a Critical Incident System (CIS) report and interview with a Resident Care Coordinator (RCC) described that a PSW had performed care on a resident that was not consistent with their transfer needs; the resident sustained a fall due to the PSW's inaction.

The resident had been identified as a moderate fall risk with specific transfer intervention that they required to ensure the residents safety.

The home's internal investigation notes identified substantiated neglect by not following the home's policies, placing a resident at risk.

Sources: CIS report; resident progress notes and care plan, internal investigation notes, home's policy "Abuse: Resident Abuse/Neglect, interviews with a RCC and other staff. [s. 20. (1)] (692)

2. The licensee has failed to ensure that a PSW complied with the home's written policy to promote zero tolerance of resident abuse/neglect, when providing care to a resident.

Emotional abuse is defined within the O. Reg. 79/10 of the LTCHA, 2007, as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident". Verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

A resident had requested a PSW to provide them assistance, when the PSW refused, they spoke to them in an inappropriate manner. Another PSW identified

that they had observed this and indicated that the resident had become very upset saying the way the PSW talked to them was "disrespectful and not dignified".

A RCC indicated that an allegation of neglect towards a resident had been founded for not complying with the home's abuse policy, as they were verbally abusive causing the resident to suffer emotional distress and a lack of dignity.

Sources: CIS report; resident progress notes and care plan; review of the internal investigation notes; home's policy "Abuse: Resident Abuse/Neglect; and interviews with a PSW, a RCC and other staff. [s. 20. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal harm to the residents resulting from the abusive actions of the staff member not complying with the home's zero tolerance of abuse/neglect policy.

Scope: The scope of this non-compliance was a pattern as it affected two of the five residents inspected for staff to resident abuse allegations.

Compliance history: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 20 (1), and one Compliance Order (CO), two Voluntary Plans of Correction (VPCs), and two Written Notifications (WN) were issued. (692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must comply with s. 6 (7) of the LTCHA.

Specifically, the licensee must:
a) ensure that resident care plan interventions related to managing their responsive behaviours are provided;
b) ensure that the two resident's care plan interventions related to their falls prevention are provided;
c) conduct weekly audits of the three resident's plans of care to ensure staff are providing care as specified in residents' plans of care, and document the audits until no further concerns are identified in the audits for a two-week period.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident had the interventions in place to manage their responsive behaviours, as specified in their care plan.

A resident was determined to be high risk for responsive behaviours towards others. The care plan for the resident indicated that staff were to ensure a barrier was in place to mitigate the resident's responsive behaviours. There were multiple observations by the Inspector where the barrier was not in place. A Behavioural Supports Ontario (BSO) PSW indicated that staff were to ensure the barrier was to be in place at all times.

Sources: CIS report; a residents care plan; Inspector's observations; and interviews with a RCC and other staff. [s. 6. (7)] (679)

2. The licensee has failed to ensure that a resident had a fall prevention item in place as specified in the plan.

Resident #007 had an unwitnessed fall, which resulted in a significant injury. A review of the CIS report indicated that the resident did not have their fall prevention item in place at the time of the fall incident.

During separate interviews with a PSW and a Registered Nurse (RN), they indicated that they had responded to the resident when they had fallen and identified that the resident did not have their fall prevention item in place, as specified in the resident's care plan.

Sources: CIS report; review of the home's "Documentation Resident Care Plan" policy; review of a resident's electronic progress notes; care plan and Fall Risk Assessment; and interviews with a PSW, a RN and other staff. [s. 6. (7)] (687)

3. The licensee has failed to ensure that a resident had a fall prevention item in place as specified in the plan.

Resident #009 had an unwitnessed fall, which resulted in an injury. A review of the resident's progress notes, indicated that the resident did not have their fall prevention item in place at the time of the fall incident.

During an interview with a RN, they verified that the resident was a high risk for falls and that when the resident fell they did not have their fall prevention item in place as stated in their care plan. A RCC stated that the staff members were to ensure that their fall prevention item was in place at all times and that the staff did not follow the residents care plan.

Sources: CIS report; review of the home's "Documentation Resident Care Plan" policy; review of resident electronic progress notes; care plan and Fall Risk Assessment; and interviews with a RN and a RCC. [s. 6. (7)]

An order was made by taking the following factors into account:

Severity: There was actual harm identified as the two residents sustained injuries resulting from falls, as they did not have the fall prevention intervention in place at the time of fall incidents.

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

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

Scope: The scope of this non-compliance was a pattern as it related to three out of six residents inspected for falls and responsive behaviours.

Compliance history: In the last 36 months, the licensee was found to be non-compliant with the LTCHA s. 6 (7). Four Voluntary Plans of Correction (VPCs) were issued. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 26, 2021

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 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:

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

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

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 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 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 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 January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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