Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: July 25, 2024
Inspection Number: 2024-1576-0002
Inspection Type: Complaint Critical Incident
Licensee: City of Greater Sudbury
Long Term Care Home and City: Pioneer Manor, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24 to 28, 2024.

The following intake(s) were inspected:
- One Critical Incident (CI) intake related to an alleged physical abuse of a resident by a staff member.
- One CI intake related to resident care concerns.
- Two CI intakes related to improper/incompetent care of a resident by a staff.
- One CI intake related to an alleged physical and verbal abuse of a resident by a staff member.
- One complaint intake related to concerns of improper/incompetent care of a resident.
- One complaint intake related to concerns of improper/incompetent care and fall incident of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services

Continence Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
a) A Registered Nurse (RN) was concerned regarding a resident's medical symptom.

A number of procedural attempts were performed to alleviate the medical symptom but were unsuccessful.

Documentation indicated that the SDM was an essential caregiver and emergency contact and was supposed to be informed of changes in the resident's condition and plan of care but, was only notified one week later when the resident had informed them.

Resident Care Coordinator (RCC) verified that the staff should have had notified the SDM of the onset of resident's medical symptom.

b) The resident's SDM was informed by staff members that the resident was observed with a medical symptom due to a procedure. However, there was no evidence to support this.

The Registered Practical Nurse (RPN) admitted that the medical symptom information was not verified but, it was reported to oncoming staff, who in turn reported incorrect information to the resident's SDM.

The home's failure to ensure that resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care impacted the resident.

Sources: Resident health care records; CI report; the home's policy; the home's internal investigation; interviews with staff members and the RCC.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that the RCC immediately forwarded to the Director a written complaint they received concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations.

Rationale and Summary
The RCC had received a written complaint concerning the care of a resident, which was not submitted to the Director immediately. They described how they had saved it in the CI reporting portal but was not submitted until it was finalized.

The home's failure to immediately forward the written complaint concerning a resident's care to the Director presented no risk to the resident as the investigation into the concerns commenced immediately.

Sources: A CI report; the home's internal investigation; interviews with North District Triage Inspector and the RCC.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director

s. 28 (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.

The licensee has failed to immediately report a suspicion of improper or incompetent resident care, and the information upon which it was based, to the Director.

Rationale and Summary

A specified PSW had received multiple disciplinary measures due to conduct concerns involving residents and provisions of resident care.

Record review indicated that no reports were submitted to the Ministry in relation to conduct concerns of this PSW on specified dates.

When the home failed to immediately report a suspicion of improper or incompetent treatment of residents by a staff member, the Director was unable to take action, if it had been merited.

Sources: Interview with the RCC; a CI report, PSW's disciplinary documentation record, and other records.

WRITTEN NOTIFICATION: Oral Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of

the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received their oral care.

Rationale and Summary
Record review of the resident's Point of Care (POC) documentation record indicated that on a specified date their oral care was not provided by a staff member.

The RCC stated and acknowledged that the PSW did not provide the oral care as indicated in the resident's plan of care.

Staff not following the oral care of a resident has increased their risk of harm.

Sources: A complaint report; resident observations, review of resident's records and the home's internal investigation report; interview with staff members and the RCC.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff were to use safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A CI was submitted to the Director related to a resident who was improperly transferred by a staff member which resulted in a fall incident with an injury.

A review of the resident's care plan record indicated that the specified resident was to be transferred by two staff extensive assistance using a transfer equipment.

A PSW and the RCC were interviewed and acknowledged that a specified resident was supposed to be transferred by two-staff extensive assistance but, this did not occur.

Staff not following the resident's safe lift and transfer protocol has placed them at increased risk of harm and injury.

Sources: A CI report; resident observation, review of resident's records and the home's policy; interview with staff members and the RCC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance of resident abuse or neglect

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (a)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

The licensee has failed to ensure the home's written policy to promote zero tolerance of resident abuse and neglect contained assessment procedures for registered staff to assist and support residents who had been abused or neglected, or allegedly abused or neglected.

In accordance with FLTCA s. 25, 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.

Rationale and Summary

On two separate incidents of staff to resident alleged physical abuse, multiple nursing assessments were identified to have not been initiated as per the home's procedures.

A) A staff member reported an allegation of a PSW physically abusing a resident to the RN. The RN had completed a written report but did not complete any assessment documentation for the specified resident.

Another assessment was completed an hour later by a different staff member and the resident was noted with injuries, but the registered staff were unable to determine whether the identified injuries were a direct result of the incident.

B) Another resident was identified with a skin integrity concern after an unwitnessed incident with the specified PSW. The RPN was notified of the resident's injury and assessment was not completed. The following day the resident was reported by PSWs to have had injuries to multiple areas of their body and another RPN had completed an assessment of the resident but did not include the new injury. The RN was interviewed related to a resident who exhibited a new injury after an unwitnessed incident. The registered staff reviewed the home's policy and

additional resources but were unable to identify what assessments registered staff should complete.

The RCC stated that registered staff should have completed the assessment and if a resident had signs of injury after an unwitnessed incident, the staff were responsible for initiating relevant assessments as per their clinical judgment at the time of the incident and/or new injuries were identified.

The home's policy on the prevention of resident abuse and neglect did not contain procedures for assessments of residents after an allegation of physical abuse. It did not include when an assessment should be initiated, the types of assessments to initiate, and the responsibilities of different staff members in relation to resident assessment after an alleged abuse.

When the home's written policy to promote zero tolerance of resident abuse and neglect did not contain procedures for registered staff to assess residents who had been allegedly abused or neglected, residents were at increased risk of undetected injury and delayed intervention.

Sources: Interviews with the RCC and other staff; record review of the home's policies.

WRITTEN NOTIFICATION: Medication Administration

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (a)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,

(a) where the administration involves the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is authorized to administer the drug by virtue of a health profession Act, the Regulated Health Professions Act, 1991 or any relevant regulation; or

The licensee has failed to ensure that no person administers a drug to a resident in the home unless the person was authorized to administer the drug by virtue of the Regulated Health Professions Act, 1991.

Rationale and Summary

A CI report was submitted to the Director, where a medication was administered by a specified PSW to a resident via a specified route, which subsequently resulted in an injury.

A PSW was interviewed, and they stated that they were unaware that they were not allowed to administer a medication to a resident via the specified route. The RPN and the RCC were both interviewed, and they stated that PSW's were not trained to administer medications to a resident.

Failure of the registered staff to recognize that PSWs in the home were not permitted to administer any medication had placed the resident at risk of harm.

Sources: A CI report; review of the resident's records and the home's policy; internal investigation reports; interview with the resident, staff members and the RCC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order in adherence with FLTCA, 2021, s. 155 (1) (a).

Specifically, the licensee must:

1. Educate the specified PSWs on the home's policy for the prevention of resident abuse and neglect. Ensure the education includes the legislative definitions of resident abuse, as well as staffs' responsibilities for immediate action in the event of suspected resident abuse.

    A record will be maintained of the education provided, who received the education, date of when the education was provided, as well as the contents of the education and/or training materials.

2. Revise the home's policy on the Prevention of Resident Abuse and Neglect to include what registered staff are expected to do in the event of physical injury to a resident following witnessed, and unwitnessed, allegations of abuse.

    Maintain a record of the revision process, including:

    i) Meeting dates, times, and notes on discussions held.

    ii) Meeting participants and their designation(s).

    iii) The outcome of the revision.

3. Educate all registered staff on the associated policy revisions.

A record will be maintained of the education provided, who received the education, date(s) of when the education was provided, as well as the contents of the education and training materials.

4. Conduct an audit of nursing assessments completed in relation to allegations of resident abuse or improper care.

a) The audit will review the nursing assessments initiated in response to reports of new resident injury or pain, for adherence with the home's policies.

b) The audit will be conducted by a member of the home's management, or clinical leadership team.

c) It will be conducted daily over a four-week period.

d) Maintain a record of the audits completed, dates of when the audits were completed, and any action taken when non-compliance is identified.

e) Analyze the results of the audits, address any concerns identified, and document the corrective actions taken.

Grounds
The licensee has failed to ensure that the specified residents were protected from abuse by the home's staff.

Section 2 (1) of the Ontario Regulation 246/22 (O. Reg. 246/22) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Additionally, section 2 (1) of the O. Reg. 246/22 defines verbal abuse 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.

Rationale and Summary

A) A specific resident had a medical diagnosis for which they exhibited specific expressions during care. Staff were expected to use a specific approach.

On a specified date, the resident was ambulating along a hallway with their mobility aid with a number of staff present. The specified PSW had approached the resident; inappropriately assisted the resident onto their mobility aid and was overheard speaking inappropriately to the resident. No staff intervened or reported this concern to a registered staff.

In a separate incident, the specified PSW had provided personal care to the same resident and had asked for assistance from another PSW. The PSW who provided additional assistance had observed that the resident had injuries and was observed to be emotional. The RN was notified, and the resident verified that the involved PSW had been physically inappropriate. Multiple new injuries were observed on the resident the following day.

The specified PSW was previously disciplined for a number of occasions for putting residents at risk of harm in the home as well as inappropriate actions during resident care.

When the licensee failed to protect a specific resident from physical abuse, they sustained injury and were at increased risk of further harm.

Sources: Interviews with PSW and other staff; a CI report; the home's internal investigation notes, and resident's clinical records.

B) Another resident had a specified medical diagnosis and a history of physical expressions during care. The home had multiple interventions in the resident's care plan for when this occurred, including for staff to use a specific approach.

Two PSWs had assisted the resident with their continence care. During personal care, the resident displayed physical expressions towards the specified PSW, but the PSW had responded to the resident in a physical and verbal inappropriate behaviour. Following this incident, the resident was noted with an injury and multiple skin integrity concerns.

When a resident was not protected from abuse by staff at the home, they were at increased risk of injury.

Sources: Interviews with the RN and other staff; review of the home's internal investigation notes, a CI report, and other records.

This order must be complied with by October 11, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the

Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.

(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.