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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2017	2017_616542_0010	009406-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE 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

JENNIFER LAURICELLA (542), ALAIN PLANTE (620), CHAD CAMPS (609), MICHELLE BERARDI (679), SARAH CHARETTE (612)

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): May 23 - 26, 2017 and May 29 - June 2, 2017.

The following intakes were completed concurrently with this Resident Quality Inspection (RQI);

Three follow up intakes were completed, one related to the staffing plan not meeting the needs of the residents and two other intakes related to Prevention of Abuse, Neglect and Retaliation.

Five complaint logs related to staff to resident abuse, and resident to resident sexual abuse and complaints regarding other care related concerns.

Four critical incident (CI) reports that were submitted to the Director alleging staff to resident abuse.

Five CI reports related to a fall of a resident resulting in an injury or transfer to a hospital.

During the course of the inspection, the inspector(s) spoke with the home's Director, Program Coordinators (PCs), Acting Manager of Resident Care, Care Conference Coordinator, Resident-Assessment-Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Dietician (RD), Registered Practical Nurses (RPNs), residents and family members.

The inspectors conducted a daily walk through of all resident care areas, observed the provision of care and services to residents, reviewed the health care records of residents, reviewed various home program policies and procedures, staff training records and employee files.

The following Inspection Protocols were used during this inspection:

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
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2017_613609_0001	609
O.Reg 79/10 s. 31. (3)	CO #002	2017_613609_0001	612

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	Legendé 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 that promoted zero tolerance of abuse and neglect of residents was complied with.

A previous Compliance Order (CO) #004 and Director's Referral (DR) was issued on March 1, 2017, to address the licensee's failure to comply with s. 20. (1) of the LTCHA, 2007 during a Follow Up Inspection #2017_613609_0001. The licensee was ordered to:

a) Ensure that all staff of the home comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.
b) Specifically ensure that a process is developed and implemented to monitor and evaluate Health Care Aide (HCA) #131's day by day performance to ensure they comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.

Full compliance with the order was expected by March 22, 2017. The home was also ordered to develop and implement a process to monitor HCA #131's performance to ensure they complied with the home's abuse policy.

While the home completed items a) and b) additional non-compliances were found.

A) Inspector #609 reviewed a complaint which was submitted to the Director that outlined how on a specific day, resident #001 may have been sexually abused by resident #031, to which resident #001's SDM was not notified until two days after the alleged incident, by the home's Medical Director.

A review of resident #031's plan of care, found that the resident was identified as high

risk for inappropriate sexual behaviours including but not limited to touching other residents inappropriately.

Inspector #609 reviewed resident #001's progress notes and found that RPN #117 was called to assess the resident who was on the floor of resident #031's room, undressed except for a brief and hip protectors, their night clothes on a chair. The RPN then notified their supervisor, RN #115 of the incident.

During an interview with RN #115 on May 30, 2017, they verified that they were called to assess resident #001. They indicated to the Inspector that they, along with the RPN assumed that no sexual abuse occurred after they had a conversation related to potential sexual abuse. When asked how they determined that no sexual abuse occurred, RN #115 indicated they did not want to "pass judgment" on what resident #031 did.

Inspector #609 reviewed the health care records of both residents which failed to have any documentation from RN #115 regarding the incident.

RN #115 further verified that potential sexual abuse could have occurred between resident #001 and resident #031 on that specific day. A review of home's abuse policy was conducted with RN #115 who verified that all employees who suspected that a resident was abused, must verbally report the allegation immediately to the home area Program Coordinator (PC) or administrative person on call if after hours.

During an interview with PC#116 they indicated that given resident #001's state of undress found in the room of resident #031 who had previous identified sexual responsive behaviours as well as the registered staff having a conversation about potential sexual abuse, would have constituted a suspicion of sexual abuse and should have been reported by RN #115 immediately to the on call administrative designate.

B) Inspector #609 reviewed a CI report which was submitted to the Director, outlining how on at least three occasions, PSW #105 emotionally abused resident #008 and #009 by interfering with the two residents' personal relationship.

Ontario Regulation 79/10 defines emotional abuse 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.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" last revised March 21, 2017, indicated that residents would be free from abuse by employees.

A review of resident #008's progress notes found that, on the specific day of the alleged incident, resident #008 and #009 were interacting with each other in resident #009's room when PSW #105 tried to remove resident #008 from the room causing resident #008 to become upset and shout at PSW #105 to mind their own business.

During an interview with RPN #111 on May 29, 2017, they verified that they were present and working on the day of the alleged incident, and that resident #008 was upset after PSW #105 tried to stop the two residents from interacting with each other.

A review of the RAI-MDS assessments since admission for both resident #008 and #009 indicated their decision-making skills were "consistent and reasonable".

A review of the home's internal investigation found that resident #008 and #009 had a personal intimate relationship. The day after the alleged incident, RN #112 attended to resident #008 who was crying and upset, after PSW #105 told the resident that they were to stay out of the resident #009's room. The investigation also found that PSW #105's remarks made resident #008 feel "dirty" and "humiliated", while resident #009 felt "not good".

The home's internal investigation found that PSW #105 emotionally and verbally abused resident #008 and #009 and received disciplinary action.

During an interview with PSW #105 on May 29, 2017, they verified that resident #008 and #009 became upset when they tried to separate them on the specific day of the incident, as well as other occasions, they thought the relationship was inappropriate.

During an interview with PC #113 on May 29, 2017, they verified that PSW #105 emotionally abused resident #008 and #009 in multiple incidents of interference in their personal relationship and did not follow the home's abuse policy.

C) Inspector #609 reviewed a CI report which was submitted to the Director, outlining allegations of emotional abuse towards resident #008 and #009 by PSW #105.

A review of the home's internal investigation found that the day after the alleged incident of abuse, RN #112 attended to resident #008 who was crying and felt "dirty" and

"humiliated" after PSW #105 told the resident that they were to stay out of the resident #009's room on the day prior.

RN #112 then notified, PC #113 by an email outlining the allegations of emotional abuse at 2014 hours.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" last revised March 21, 2017, indicated that all employees who have witnessed or suspected that a resident was being abused or neglected, must verbally report the allegation immediately to the home area PC or administrative person on call if after hours.

During an interview with the PC #113 on May 29, 2017, they indicated that they did not become aware of the allegation of abuse by PSW #105 until two days after the alleged incident when they returned to work and reviewed their emails. PC #113 verified that RN #112 did not follow the home's abuse policy when they failed to verbally report the allegation of abuse immediately to the on call administrative person.

D) Inspector #602 reviewed a CI report that was submitted to the Director, alleging that staff to resident emotional/physical abuse had occurred on a specific day. A review of the CI report revealed that PSW #109 witnessed and reported that PSW #106 verbally abused resident #011.

Ontario Regulation 79/10 describes verbal abuse as,

(a) 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.

Inspector #620 reviewed the home's investigation notes related to the CI report and identified that on the day of the alleged incident, PSW #109 reported to their immediate supervisor that PSW #106 had sworn at resident #011 following an episode of incontinence. PSW #109 indicated in their report that resident #011 appeared frightened by PSW #106's actions.

Inspector #620 reviewed a document addressed to PSW #106 from the licensee that indicated that as a result of the home's investigation, the home was satisfied that the staff member, "did curse and become upset with the resident, causing them to become fearful."

Inspector #620 reviewed a document titled, "Abuse: Resident Abuse/Neglect" with a review date of March 21, 2017. The document described verbal abuse verbatim from the Ontario Regulation 79/10. The document also stated that, "Pioneer Manor has a policy of not tolerating resident abuse."

On May 30, 2017, Inspector #620 interviewed PC #107, who indicated that PSW #106 did not adhere to the home's policy on zero tolerance of abuse. They indicated that resident #011 had been verbally abused by PSW #106 and that they had been disciplined as a result of the verbal abuse.

E) Inspector #542 reviewed a CI report that was submitted to the Director, alleging staff to resident physical and emotional abuse. The alleged incident occurred on a specific day according to the CI report, when PSW #104 had assisted resident #007 with repositioning causing them pain. Resident #007 had called out in pain, however PSW #104 continued to reposition the resident. Resident #007 had reported to RPN #123 that they no longer wanted PSW #104 to care for them. Five days after the alleged incident, PSW #104 then approached resident #007 in their room and informed them that they were aware that they reported them and that they could lose their job. Resident #007 stated that they felt fearful and intimidated with this exchange.

On May 29, 2017, Inspector #542 reviewed the home's investigation file which included documentation from PC #107. The PC documented that resident #007's family member had approached them six days after the alleged incident in attempt to find out about the results of resident #007's complaints regarding PSW #104. Resident #007's family member informed PC #107 that the resident had reported the alleged abuse to RPN #123 and thought that they had reported it to PC #107. The investigation notes also indicated that the home conducted an investigation 6 days after the incident was reported via email. A review of the investigation notes also disclosed that PSW #104 returned to resident #007's room five days after the incident to tell them that they knew that resident #007 had reported them and that they could lose their job. Resident #007 stated that they were fearful and felt intimidated by PSW #104.

On May 30, 2017, Inspector #542 interviewed PC #107 who indicated that they had missed the email that was sent to them a day after the alleged incident by RPN #123 regarding the allegations of abuse towards resident #007.

On May 30, 2017, Inspector #542 interviewed RPN #123 who was able to provide the

Inspector with a copy of the email that they sent to PC #107 the day after the alleged incident at a specific time regarding the allegation of abuse. The email indicated that the actual alleged incident occurred on a specific day, however it was reported to the RPN the next day by resident #007. Inspector #542 asked RPN #123 what occurred after they were made aware of the alleged incident of abuse. They indicated that PSW #104 continued to work their entire shift on the day when the alleged abuse occurred, until their shift was completed and that PC #107 did not provide them with further direction until the next day. RPN #123 also stated that they reported the alleged abuse to the RN that was on charge that shift however they could not remember the RN's name.

Inspector #542 completed a review of PSW #104's employee file which revealed disciplinary actions for the above incident and two additional incidents of improper and neglectful care.

On May 30, 2017, Inspector #542 interviewed resident #007 in their room. Resident #007 was able to recall the incident as indicated on the CI report. Resident #007 stated that PSW #104 continued to reposition them in bed causing them pain and they could not understand why PSW #104 continued even though they were calling out in pain. Resident #007 stated that they reported it to RPN #123 and informed them that they did not want PSW #104 to care for them anymore. Resident #007 also stated that PSW #104 approached them after the incident while they were lying in bed and informed them that they could lose their job causing them to feel fearful and intimidated by PSW #104.

On June 1, 2017, Inspector #542 interviewed PSW #104, who indicated that they recalled the incident and denied that it occurred. PSW #104 also indicated that some of their co-workers had informed them that resident #007 was complaining about them. PSW #104 then stated that RPN #123 spoke with them. PSW #104 stated that they know now that they should not have approached the resident after the incident. PSW #104 no longer provides care to resident #007.

Inspector #542 reviewed the home's policy titled, "Abuse: Resident Abuse/Neglect" revised March 21, 2017. The policy identified that all employees who have witnessed or suspected abuse/neglect must verbally report the allegation immediately to the home area Program Coordinator or Administrative Person on Call if after hours. The home failed to follow the policy with regards to verbally reporting the allegation, instead an email was sent to the PC which wasn't found until 6 days after the alleged incident, thus allowing PSW #104 to remain working in the home. It was also documented in the policy that, "residents will be free from abuse by employees." The home's policy describes

some examples of physical abuse but not limited to, as; use of physical force by anyone other than a resident that causes pain to which PSW #104 failed to comply with. The home's policy also identified emotional abuse as; any intimidating gestures, actions and or behaviours. PSW #104 left resident #007 to feel intimidated and fearful due to their actions. Furthermore it was indicated in the policy that the police were to be notified immediately of any alleged, suspected or witnessed abuse or neglect of a resident that may constitute a criminal offence.

On June 8, 2017, Inspector #542 spoke with the Acting Manager of Resident Care to discuss when the police would be notified as per the home's procedure. The Acting Manager of Resident Care verified that they were part of the disciplinary meetings regarding this incident and indicated that based on the home's policy, intimidating a resident would warrant for the police to be notified. The police were not notified of this incident. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker, if any.

During a family interview, resident #019's family stated that they had not been invited to participate in the residents care conference for year 2016.

In an interview with RN #119 on May 31, 2017, they identified that care conferences are to be held within six weeks of admission, annually and as required.

Inspector #679 reviewed the resident's paper chart, and was unable to locate a care conference record for the year 2016.

Inspector #679 and the Care Conference Coordinator #124 reviewed the home's care conference schedule and could not locate documentation that resident #019's care conference was held for the 2016 year.

During an interview with the Care Conference Coordinator #124 on May 31, 2017, they confirmed that care conferences were to be completed within six weeks of admission and annually, thereafter, and that no care conference was held for resident #019 in 2016. [s. 27. (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 a care conference of the interdisciplinary team is held annually to discuss the plan of care and any other matters of importance to resident #019 and their substitute decision maker, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dietary services and hydration program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and that a written record relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, and a summary of the changes made and the date that those changes were implemented.

Inspector #620 identified non-compliance related to course-by-course meal services; for further information refer to WN #7. As a result Inspector #620 reviewed the nutritional service and hydration program and identified that the program's last revision occurred in June 2010.

Inspector # 620 attempted to locate documentation related to the annual evaluation and revision of the nutritional service and hydration program but was unable to locate this documentation.

During an interview with Inspector #620 on June 1, 2017, the Food Service Manager indicated that they were currently working towards the analysis and review of the program; however, the work was incomplete. The Food Service Manager confirmed that the nutrition and hydration program had not been reviewed annually since 2010 and that the program was currently outdated. [s. 30. (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 the dietary services and hydration program is evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and that a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, and a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On May 23, 2017, during the initial tour of the home, Inspector #679 observed unlabelled and used toiletries in various home areas, including but not limited to linen carts in hallways, tub rooms and dining room cupboards.

In an interview with PSW #130 and RPN #120, on May 31, 2017, they indicated to Inspector #679 that it was the expectation of the home that the resident's personal belongings were labelled.

In an interview with Inspector #679 on June 1, 2017, Program Coordinator #116 confirmed that it was the expectation of the home that all personal items were to be labelled. [s. 37. (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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

On May 31, 2017, during an interview with Inspector #612, resident #042 stated to the Inspector that it took the staff a long time to assist them when they rang the call bell.

On May 31, 2017, Inspector #612 observed at 1620 hours, that resident #042's call bell was sounding. The Inspector entered the resident's room and observed that they were wheeling themselves out of the washroom. The Inspector asked the resident if they required assistance. The resident stated to the Inspector that they had rang their call bell at approximately 1545 hours and that no one came so a visitor had assisted them to the washroom.

The Inspector #612 interviewed RPN #117 who arrived at resident #042's room at approximately 1627 hours to provide medication. RPN #117 asked the resident if they required further assistance and the resident replied that they had already been assisted by a visitor. The RPN stated that the PSWs were in other residents rooms.

Inspector #612 reviewed the resident's current care plan which stated that the resident required the assistance of one staff member.

Inspector #612 reviewed the call bell report and noted that the resident rang the washroom call bell at 1539 hours and the call bell was canceled at 1627 hours.

Inspector #612 reviewed the home's policy titled, "Call System- Communication and Response, last reviewed May 11, 2015, which stated that the personal alert system provided a means of timely communication for residents to their caregivers.

On June 2, 2017, Inspector #612 interviewed the Acting Manager of Resident Care who stated that they were not aware if there were specific time lines established for answering a call bell, however, stated that the call bell should not have been left that long. [s. 51. (2) (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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a weight change of 7.5% per cent of body weight, or more, over three months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

A health care record review was completed by Inspector #679 for resident #023 who was identified as having an eating decline and significant weight loss, with no interventions.

A review of the electronic weight records by Inspector #679, identified that resident #023 had a documented weight loss of 10 percent of their body weight over a three month period.

A review of the progress notes found that resident #023 was assessed by Registered Dietitian (RD) #118 during the period of the weight loss. A review of resident #023's electronic nutrition notes, as well as the resident's care plan indicated that no nutritional interventions were in place to address the resident's significant weight loss.

A review of the homes policy titled "Resident Care Policies and Procedures: Weight Changes", last revised October 20, 2016, identified that for any resident who had experienced an unplanned weight change of 5 percent or more over one month, 7.5 per cent or more over three months or 10 percent or more over six months, nutritional services were to conduct a "thorough assessment of residents referred, investigate possible nutritional factors responsible for the weight change and modify the resident's care plan to implement nutritional interventions required".

During an interview with Inspector #679 on May 31, 2017, RD #118 confirmed that there were no nutritional interventions to address significant weight loss in place for resident #023 as they were allowing the resident time to transition to the home. [s. 69. 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 an interdisciplinary approach, and that actions are taken and outcomes evaluated to address the a weight change of 7.5% per cent of body weight, or more, over three months for resident #023, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During the following dining observations, Inspector #620 observed:

On May 24, 2017, Inspector #620 observed resident #035 in the dining room on a specific home area being served their dessert while they were still eating their lunch meal.

On May 26, 2017, Inspector #620 observed resident #036 in the dining room of another home area, being served their lunch entrée while they were still consuming their soup.

On May 26, 2017, Inspector #620 observed resident #024 in the dining room on a different home area being served their dessert while their lunch entrée was still being consumed.

Inspector #620 reviewed the care plans for residents #024, #035, and #036 and there was no indication that any of these residents should not have received their meals course by course. All of the above resident's were not interviewable.

A review of the home's policy titled Nutritional Services – Meal Service, last revised June 1, 2010, stated that foods were to be served course by course, unless contraindicated in the resident's plan of care and that soiled dishes were to be removed between courses.

During an interview with the Inspector #620 on May 30, 2017, the Manager of Food Services confirmed that it was the home's expectation that meals were to be served one course at a time unless indicated in the resident's care plan. [s. 73. (1) 8.]

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 has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

WN #8: 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
- an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Ontario Regulation 79/10 describes a significant change as a major change in the resident's health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care. O. Reg. 246/13, s. 9 (5).

A) Inspector #620 reviewed a CI report that was submitted to the Director five days after the incident where resident #012 had a fall and was transferred to the hospital. The fall

resulted in a significant change with regards to resident #012's health condition due to a fracture. The report also indicated that 12 days after the fall, resident #012 passed away; the death certificate indicated that resident #012 died of a specific disease secondary to complications related to the fracture.

Inspector #620 reviewed a document titled, "Documentation: Report of Critical Incidents" with a last revised date of August 03, 2016. The document defined an incident as, "any happening which is not consistent with the routine and/or operation of the home. This may be an accident or a situation which is might result in an accident, or an incident or any occurrence involving a resident, visitor or staff. For example a resident fall…" The document also indicated that an incident that caused an injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, was to be reported to the Director within one business day by the Program Coordinator.

Inspector #620 interviewed RN #108 who indicated that they assessed the resident post-fall and that they suspected a fracture due to their assessment. They indicated that they notified PC #116 that the resident had experienced a fall and that they had transferred the resident to hospital via emergency services.

Inspector #620 reviewed email correspondence sent from RN #108 to PC #116 on the day when the resident had fallen. The email indicated that the resident's family member had contacted RN #108 and confirmed a fracture and noted that the resident was to receive surgical intervention for the fracture.

Inspector #620 interviewed PC #116 who indicated that they had not notified the Director within one business day of becoming aware of the resident #012's significant change in condition. They indicated that they were unaware a report needed to be made to the Director within one business day.

B) Inspector #612 reviewed a Critical Incident (CI) report that was submitted to the Director by PC #116 six days after a resident's fall that resulted in a transfer to the hospital. The CI report described that on the day of the fall, resident #001 was found on the floor in their bedroom. Upon assessment, the resident was noted to have shortening to the left leg and pain with movement of the left leg and hip. The resident was sent to the emergency department for further assessment.

Inspector #612 reviewed resident #001's progress notes and noted that there was a

progress note completed the following day, which stated that RN #135 had contacted the hospital and they confirmed that the resident was admitted to hospital, had a fracture and were awaiting surgery.

Inspector #620 reviewed a document titled, "Documentation: Report of Critical Incidents" with a last revised date of August 03, 2016. The document defined an incident as, "any happening which is not consistent with the routine and/or operation of the home. This may be an accident or a situation which is might result in an accident, or an incident or any occurrence involving a resident, visitor or staff. For example a resident fall…" The document also indicated that residents who experienced an incident that caused an injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, was to be reported to the Director within one business day by the Program Coordinator.

On June 1, 2017, Inspector #612 interviewed PC #116 who confirmed that they had not notified the Director within the time frame indicated in the legislation. PC #116 stated that they thought they had ten days to notify the Director via the Critical Incident report system. [s. 107. (3) 4.]

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 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): 4. An injury in respect of which a person is taken to hospital and, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Inspector #620 reviewed a CI report that was submitted to the Director alleging staff to resident emotional/physical abuse. A review of the CI report by Inspector #620 indicated that resident #011 was provided with improper care by PSW #106 and that the improper care was witnessed and reported by PSW #109.

Inspector #620 reviewed resident #011's care plan, active on the date of the incident. The care plan indicated that specific interventions were in place regarding how the staff were to transfer the resident due to a previous injury.

Inspector #620 reviewed the home's investigation notes related to the CI report and identified that on the day prior to the submission of the CI report, PSW #109 reported to their immediate supervisor that PSW #106 had transferred resident #011 incorrectly. PSW #109 questioned the actions of PSW #106; PSW #106 responded by saying, "it's just easier doing it this way."

Inspector #620 reviewed a document addressed to PSW #106 from the licensee that indicated that as a result of the home's investigation, the home was satisfied that the staff member knowingly transferred the resident improperly, putting the resident in physical danger. Disciplinary action was taken as a result of the incident.

Inspector #620 reviewed a document titled, "Minimal Lift Program" with a last revision date of October 14, 2016. The document advised staff to, "adhere to the designated lift/transfer status as identified on each residents care plan and kardex."

On May 30, 2017, Inspector #620 interviewed PSW #106. PSW #106 indicated that they were aware that resident #011's plan of care required specific interventions for transferring the resident. PSW #106 indicated that they transferred the resident without utilizing the specific interventions as per the resident's plan of care.

On May 30, 2017, Inspector #620 interviewed PC #107 who indicated that resident #011 had been transferred incorrectly by PSW #106 and that they had been disciplined as a result of the improper transfer. [s. 36.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate footwear.

On May 29, 2017, Inspector #542 made observations in the dining room on a specific home area between 1607 hours (hrs) and 1627 hrs. Inspector #542 observed residents #014, #021 and #033 in their night clothes. Inspector #542 reviewed the care plans for all of the above mentioned residents and was unable to locate any information regarding dressing the resident's in their night clothes at supper.

On May 30, 2017, Inspector #542 made observations in the dining room on the same home area at 1656 hrs. Inspector #542 observed resident #043 and #044 in their night clothes at the dinner table.

Inspector #542 interviewed RPN #138 who stated that when a resident is transferred to bed immediately after supper, the staff generally dress them in their night clothes at supper. They also stated that this was included in resident care plans. They verified that resident #044 was not typically dressed in their night clothes at dinner and they did not know why they were on this night.

Inspector #542 also observed on another home area on May 30, 2017, and noted that resident #004 and #034 were dressed in night clothes in the dining room. Resident #004 was dressed in a hospital type gown with bare legs being exposed. Resident #034 had a pajama shirt on, with bare legs and a blanket draped over their legs. Inspector #542 reviewed both resident's care plans and was unable to identify that they were to wear their night clothes to dinner.

On May 31, 2017, Inspector #542 interviewed RN #115 at 1738 hrs, who indicated that it should be documented in each resident's care plan as to how they were to be dressed. They also stated that when the home does not have a full complement of staff then they will sometimes dress the resident's in their night clothes before supper.

On May 31, 2017, resident #037 reported to Inspector #612 that during the dinner meal, many residents were dressed in their night clothes. Resident #037 stated that after their bath on May 28, 2017, the PSW staff had asked them if they were alright with wearing their night clothes to supper. The resident stated that they do not like to wear their night clothes to supper however, they wanted to ensure that they received their tub bath so they agreed.

On May 31, 2017, Inspector #612 observed the dining service on another home area. The Inspector observed resident #034, #038, #039, #040, and #041, in the dining room dressed in their night clothes.

Inspector #612 interviewed PSW #137 who stated that resident #034 and #039 chose to be in their night clothes, resident #038 and #040's family had agreed that they could be in their night clothes at dinner time and that resident #041 was scheduled for a bath right after dinner, therefore, they dressed the resident in a hospital style gown prior to dinner to facilitate the bath after supper. The PSW stated that the information should be included in the resident's care plans related to dressing.

Inspector #612 reviewed resident #034, #038, #039, #040 and #041's care plans and was unable to locate direction related to wearing their night clothes at dinner time. The Inspector noted that each care plan contained an intervention which stated to ensure that clothing and footwear was clean and appropriate.

On June 2, 2017, Inspector #612 interviewed resident #039. They stated that they did not like to be in the dining room in night clothes and their preference was to change into their night clothes after dinner time.

On June 2, 2017, Inspector #612 interviewed the PC #107 who stated that residents should not be in the dining room in their night clothes unless there had been a discussion with the resident or their SDM and that information was included in their care plan. [s. 40.]

WN #11: 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 medication was stored in an area that was used exclusively for drugs and drug related supplies.

A) On May 23, 2017, during a tour of the home, Inspector #679 observed a cupboard labelled "lactulose" in each of the four home areas dining room. Subsequently, the Inspector observed a registered staff member preparing medication from a drawer in the dining room of a specific home area.

In an interview with RPN #134 on June 1, 2017, they identified that all resident medications, including narcotics, were stored within the locked cupboards "medication station" in the dining rooms of each pod, in the Lodge home area.

B) On May 23, 2017, during a tour of the home, Inspector #679 observed one bottle of prescribed medicated shampoo in the tub room of a specific home area, one jar of prescribed medicated cream located on an unattended linen cart in the hallway of another home area, and one jar of medicated prescription cream on an unattended linen cart in another home area.

In an interview with RPN #131 on June 1, 2017, they identified that all medications, including medicated creams are to be stored within a locked medication area.

A review of the policy titled "Resident Care Policies and Procedures: Medication Administration" last revised October 20, 2016, identified that "all residents multi-use vials/containers ie: eye drops, nasal sprays, creams are to be stored in each resident's pouch porter". The policy further identified that after the medication is administered, the medication container is to be returned to the medication cart.

In an interview with PC #116 on June 1, 2017, they confirmed that it was the expectation of the home that all medicated creams were returned to the registered staff to be locked within the medication room. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #679 observed the 1230 hours (hrs) medication pass on a specific home area, on May 31, 2017. The Inspector observed RPN #133 retrieve a narcotic medication from a locked box, located in the locked bottom drawer of the medication station, in the homes dining room.

A review of the policy entitled "Medication Administration" last revised October 20, 2016, identified under the subheading "Medication Cart" that the exception is Lodge first floor where there is a medication station in each neighborhood to store the medication for their eight residents versus a cart". Additionally, under the subheading "Medication Station" the policy identified "The lodge first floor where there is a medication station set up in each neighborhood has a desk with locked drawers containing multi-dose medication pouches stored in pouch porters for their eight residents".

In an interview with RPN #134 on June 1, 2017, they identified that all narcotics were to be kept within the locked box in the bottom drawer of the medication station, in each home area dining room, and not within the medication room located in the Lodge.

In an interview with PC #116 on June 1, 2017, they identified that narcotic medications were stored in a double locked box the medication station, on each of the home units in the Lodge. [s. 129. (1) (b)]

Issued on this 29th day of August, 2017

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

Ministére 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) :	JENNIFER LAURICELLA (542), ALAIN PLANTE (620), CHAD CAMPS (609), MICHELLE BERARDI (679), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2017_616542_0010
Log No. / No de registre :	009406-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 31, 2017
Licensee / Titulaire de permis :	THE 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

To THE 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

Ministére 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)

Linked to Existing Order / Lien vers ordre existant: 2017_613609_0001, CO #004;

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 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;

b) ensure that the resident's Substitute Decision Maker is notified immediately regarding any alleged, suspected or witnessed abuse or neglect of a resident;

c) ensure the police are notified when an incident that may constitute a criminal offence occurs;

d) develop and implement a process to ensure that staff are aware and understand what constitutes a suspicion of sexual abuse and that they report it immediately and,

e) develop and implement a plan to monitor PSW #104, PSW #105 and PSW #106's overall performance towards all residents of the home.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promoted zero

tolerance of abuse and neglect of residents was complied with.

A previous Compliance Order (CO) #004 and Director's Referral (DR) was issued on March 1, 2017, to address the licensee's failure to comply with s. 20. (1) of the LTCHA, 2007 during a Follow Up Inspection #2017_613609_0001. The licensee was ordered to:

a) Ensure that all staff of the home comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.
b) Specifically ensure that a process is developed and implemented to monitor and evaluate Health Care Aide (HCA) #131's day by day performance to ensure they comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.

Full compliance with the order was expected by March 22, 2017. The home was also ordered to develop and implement a process to monitor HCA #131's performance to ensure they complied with the home's abuse policy.

While the home completed items a) and b) additional non-compliances were found.

A) Inspector #609 reviewed a complaint which was submitted to the Director that outlined how on a specific day, resident #001 may have been sexually abused by resident #031, to which resident #001's SDM was not notified until two days after the alleged incident, by the home's Medical Director.

A review of resident #031's plan of care, found that the resident was identified as high risk for inappropriate sexual behaviours including but not limited to touching other residents inappropriately.

Inspector #609 reviewed resident #001's progress notes and found that RPN #117 was called to assess the resident who was on the floor of resident #031's room, undressed except for a brief and hip protectors, their night clothes on a chair. The RPN then notified their supervisor, RN #115 of the incident.

During an interview with RN #115 on May 30, 2017, they verified that they were called to assess resident #001. They indicated to the Inspector that they, along with the RPN assumed that no sexual abuse occurred after they had a conversation related to potential sexual abuse. When asked how they

determined that no sexual abuse occurred, RN #115 indicated they did not want to "pass judgment" on what resident #031 did.

Inspector #609 reviewed the health care records of both residents which failed to have any documentation from RN #115 regarding the incident.

RN #115 further verified that potential sexual abuse could have occurred between resident #001 and resident #031 on that specific day. A review of home's abuse policy was conducted with RN #115 who verified that all employees who suspected that a resident was abused, must verbally report the allegation immediately to the home area Program Coordinator (PC) or administrative person on call if after hours.

During an interview with PC#116 they indicated that given resident #001's state of undress found in the room of resident #031 who had previous identified sexual responsive behaviours as well as the registered staff having a conversation about potential sexual abuse, would have constituted a suspicion of sexual abuse and should have been reported by RN #115 immediately to the on call administrative designate.

B) Inspector #609 reviewed a CI report which was submitted to the Director, outlining how on at least three occasions, PSW #105 emotionally abused resident #008 and #009 by interfering with the two residents' personal relationship.

Ontario Regulation 79/10 defines emotional abuse 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.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" last revised March 21, 2017, indicated that residents would be free from abuse by employees.

A review of resident #008's progress notes found that, on the specific day of the alleged incident, resident #008 and #009 were interacting with each other in resident #009's room when PSW #105 tried to remove resident #008 from the room causing resident #008 to become upset and shout at PSW #105 to mind their own business.

During an interview with RPN #111 on May 29, 2017, they verified that they were present and working on the day of the alleged incident, and that resident #008 was upset after PSW #105 tried to stop the two residents from interacting with each other.

A review of the RAI-MDS assessments since admission for both resident #008 and #009 indicated their decision-making skills were "consistent and reasonable".

A review of the home's internal investigation found that resident #008 and #009 had a personal intimate relationship. The day after the alleged incident, RN #112 attended to resident #008 who was crying and upset, after PSW #105 told the resident that they were to stay out of the resident #009's room. The investigation also found that PSW #105's remarks made resident #008 feel "dirty" and "humiliated", while resident #009 felt "not good".

The home's internal investigation found that PSW #105 emotionally and verbally abused resident #008 and #009 and received disciplinary action.

During an interview with PSW #105 on May 29, 2017, they verified that resident #008 and #009 became upset when they tried to separate them on the specific day of the incident, as well as other occasions, they thought the relationship was inappropriate.

During an interview with PC #113 on May 29, 2017, they verified that PSW #105 emotionally abused resident #008 and #009 in multiple incidents of interference in their personal relationship and did not follow the home's abuse policy.

C) Inspector #609 reviewed a CI report which was submitted to the Director, outlining allegations of emotional abuse towards resident #008 and #009 by PSW #105.

A review of the home's internal investigation found that the day after the alleged incident of abuse, RN #112 attended to resident #008 who was crying and felt "dirty" and "humiliated" after PSW #105 told the resident that they were to stay out of the resident #009's room on the day prior.

RN #112 then notified, PC #113 by an email outlining the allegations of

emotional abuse at 2014 hours.

A review of the home's policy titled "Abuse: Resident Abuse/Neglect" last revised March 21, 2017, indicated that all employees who have witnessed or suspected that a resident was being abused or neglected, must verbally report the allegation immediately to the home area PC or administrative person on call if after hours.

During an interview with the PC #113 on May 29, 2017, they indicated that they did not become aware of the allegation of abuse by PSW #105 until two days after the alleged incident when they returned to work and reviewed their emails. PC #113 verified that RN #112 did not follow the home's abuse policy when they failed to verbally report the allegation of abuse immediately to the on call administrative person.

D) Inspector #602 reviewed a CI report that was submitted to the Director, alleging that staff to resident emotional/physical abuse had occurred on a specific day. A review of the CI report revealed that PSW#109 witnessed and reported that PSW #106 verbally abused resident #011.

Ontario Regulation 79/10 describes verbal abuse as,

(a) 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.

Inspector #620 reviewed the home's investigation notes related to the CI report and identified that on the day of the alleged incident, PSW #109 reported to their immediate supervisor that PSW #106 had sworn at resident #011 following an episode of incontinence. PSW #109 indicated in their report that resident #011 appeared frightened by PSW #106's actions.

Inspector #620 reviewed a document addressed to PSW #106 from the licensee that indicated that as a result of the home's investigation, the home was satisfied that the staff member, "did curse and become upset with the resident, causing them to become fearful."

Inspector #620 reviewed a document titled, "Abuse: Resident Abuse/Neglect"

with a review date of March 21, 2017. The document described verbal abuse verbatim from the Ontario Regulation 79/10. The document also stated that, "Pioneer Manor has a policy of not tolerating resident abuse."

On May 30, 2017, Inspector #620 interviewed PC #107, who indicated that PSW #106 did not adhere to the home's policy on zero tolerance of abuse. They indicated that resident #011 had been verbally abused by PSW #106 and that they had been disciplined as a result of the verbal abuse.

E) Inspector #542 reviewed a CI report that was submitted to the Director, alleging staff to resident physical and emotional abuse. The alleged incident occurred on a specific day according to the CI report, when PSW #104 had assisted resident #007 with repositioning causing them pain. Resident #007 had called out in pain, however PSW #104 continued to reposition the resident. Resident #007 had reported to RPN #123 that they no longer wanted PSW #104 to care for them. Five days after the alleged incident, PSW #104 then approached resident #007 in their room and informed them that they were aware that they reported them and that they could lose their job. Resident #007 stated that they felt fearful and intimidated with this exchange.

On May 29, 2017, Inspector #542 reviewed the home's investigation file which included documentation from PC #107. The PC documented that resident #007's family member had approached them six days after the alleged incident in attempt to find out about the results of resident #007's complaints regarding PSW #104. Resident #007's family member informed PC #107 that the resident had reported the alleged abuse to RPN #123 and thought that they had reported it to PC #107. The investigation notes also indicated that the home conducted an investigation 6 days after the incident was reported via email. A review of the investigation notes also disclosed that PSW #104 returned to resident #007's room five days after the incident to tell them that they knew that resident #007 had reported them and that they could lose their job. Resident #007 stated that they were fearful and felt intimidated by PSW #104.

On May 30, 2017, Inspector #542 interviewed PC #107 who indicated that they had missed the email that was sent to them a day after the alleged incident by RPN #123 regarding the allegations of abuse towards resident #007.

On May 30, 2017, Inspector #542 interviewed RPN #123 who was able to provide the Inspector with a copy of the email that they sent to PC #107 the day

after the alleged incident at a specific time regarding the allegation of abuse. The email indicated that the actual alleged incident occurred on a specific day, however it was reported to the RPN the next day by resident #007. Inspector #542 asked RPN #123 what occurred after they were made aware of the alleged incident of abuse. They indicated that PSW #104 continued to work their entire shift on the day when the alleged abuse occurred, until their shift was completed and that PC #107 did not provide them with further direction until the next day. RPN #123 also stated that they reported the alleged abuse to the RN that was on charge that shift however they could not remember the RN's name.

Inspector #542 completed a review of PSW #104's employee file which revealed disciplinary actions for the above incident and two additional incidents of improper and neglectful care.

On May 30, 2017, Inspector #542 interviewed resident #007 in their room. Resident #007 was able to recall the incident as indicated on the CI report. Resident #007 stated that PSW #104 continued to reposition them in bed causing them pain and they could not understand why PSW #104 continued even though they were calling out in pain. Resident #007 stated that they reported it to RPN #123 and informed them that they did not want PSW #104 to care for them anymore. Resident #007 also stated that PSW #104 approached them after the incident while they were lying in bed and informed them that they could lose their job causing them to feel fearful and intimidated by PSW #104.

On June 1, 2017, Inspector #542 interviewed PSW #104, who indicated that they recalled the incident and denied that it occurred. PSW #104 also indicated that some of their co-workers had informed them that resident #007 was complaining about them. PSW #104 then stated that RPN #123 spoke with them. PSW #104 stated that they know now that they should not have approached the resident after the incident. PSW #104 no longer provides care to resident #007.

Inspector #542 reviewed the home's policy titled, "Abuse: Resident Abuse/Neglect" revised March 21, 2017. The policy identified that all employees who have witnessed or suspected abuse/neglect must verbally report the allegation immediately to the home area Program Coordinator or Administrative Person on Call if after hours. The home failed to follow the policy with regards to verbally reporting the allegation, instead an email was sent to the PC which wasn't found until 6 days after the alleged incident, thus allowing PSW #104 to

remain working in the home. It was also documented in the policy that, "residents will be free from abuse by employees." The home's policy describes some examples of physical abuse but not limited to, as; use of physical force by anyone other than a resident that causes pain to which PSW #104 failed to comply with. The home's policy also identified emotional abuse as; any intimidating gestures, actions and or behaviours. PSW #104 left resident #007 to feel intimidated and fearful due to their actions. Furthermore it was indicated in the policy that the police were to be notified immediately of any alleged, suspected or witnessed abuse or neglect of a resident that may constitute a criminal offence.

On June 8, 2017, Inspector #542 spoke with the Acting Manager of Resident Care to discuss when the police would be notified as per the home's procedure. The Acting Manager of Resident Care verified that they were part of the disciplinary meetings regarding this incident and indicated that based on the home's policy, intimidating a resident would warrant for the police to be notified. The police were not notified of this incident.

Previous non compliance has been issued, during inspection #2015_282543_0018 a Written Notification (WN) was issued on August 25, 2015, a Compliance Order (CO) was served on January 8, 2016 during a Resident Quality Inspection (RQI) #2015_391603_0029, a CO was served on May 24, 2016 during a Follow Up Inspection #2016_320612_0010 and a CO was reissued along with a Director's Referral (DR) on March 1, 2017. Despite ongoing non compliance, the home continues to have on going non compliance with this area of the legislation.

The decision to re-issue this compliance order was based on the scope, which affected five different residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued, three compliance orders have been issued within the last fourteen months with this area of the legislation. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 18, 2017

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

Ministére 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

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 31st day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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